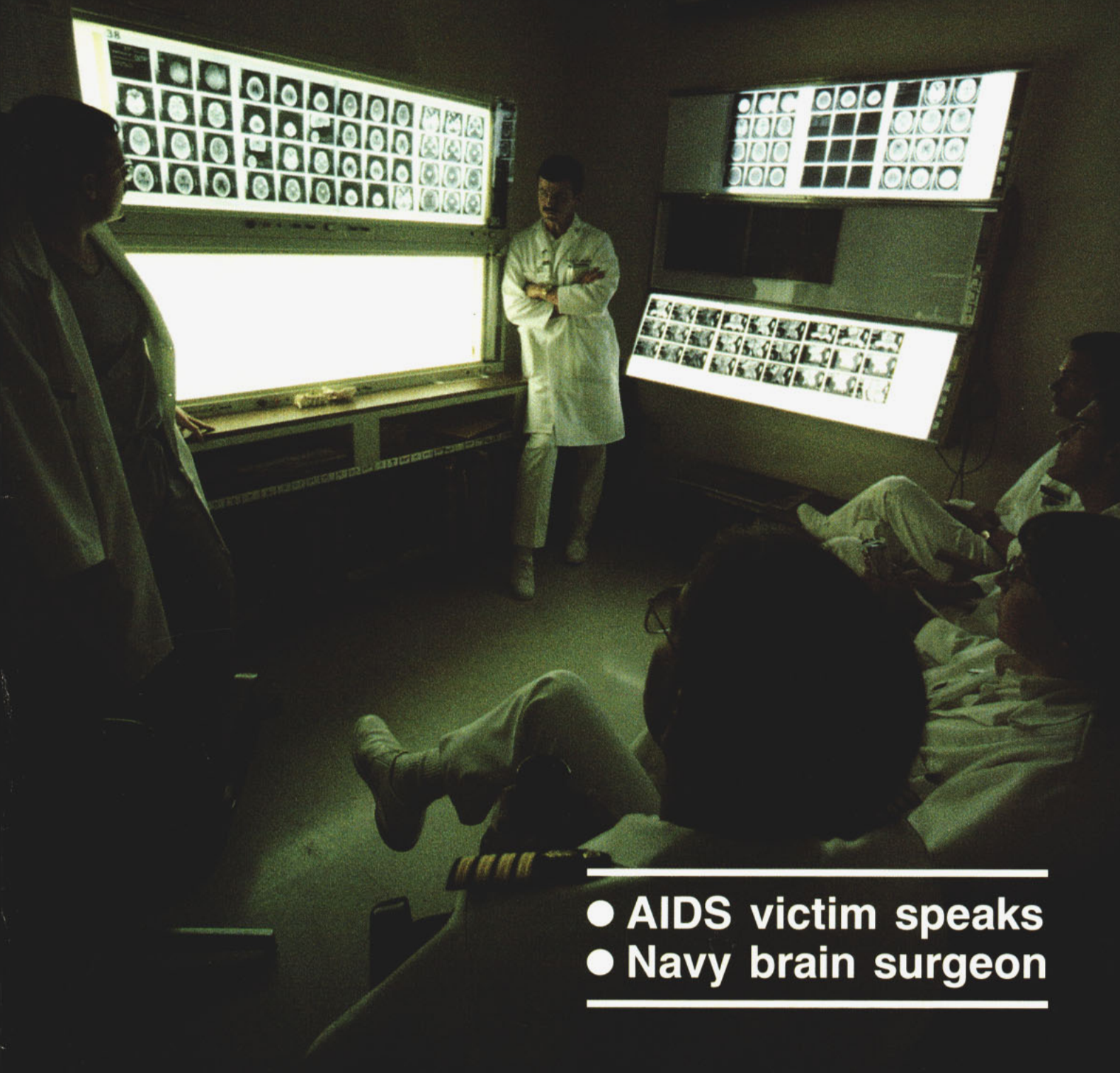


ALL HANDS

MAGAZINE OF THE U.S. NAVY

NOVEMBER 1987



- AIDS victim speaks
- Navy brain surgeon

The CNO on Navy Medicine

Each visit I make to a ship or shore station invariably brings up several questions from our people about medical care. I would like to talk with you about this issue, and about what we are doing to improve our medical care program now and in the years ahead.

The principal goal of Navy medicine is to maintain the highest possible state of readiness that will ensure prompt, effective medical care of combat and support forces in time of conflict and meet medical care requirements for active duty personnel, their dependents and our retired community. Title 10 of the U.S. Code provides for in-house dependent and retiree health care on a *space available* basis, and this fully supports what I believe is the Navy's moral obligation to provide medical care to *all* Navy beneficiaries. The Navy also provides *direct* health care at its own facilities for unique and specialized medical requirements of Navy beneficiaries. This direct care permits increased medical professional development and proficiency across a wide spectrum of medicine.

The quality of Navy medical care over the years has remained exceptionally high. Our standards for physicians, nurses and other health care people seeking to enter the Navy match the highest in the nation. Our hospitals are required to meet and do meet the same strict accreditation standards as civilian hospitals. Although we now face certain reductions by Congress in our personnel and budgetary plans, quality care is not something Navy medical professionals will compromise when your health or your family's health is involved.

Improved physician-patient contact is a primary goal of every Navy doctor and contributes significantly to top quality Navy medicine. Access to this excellent health care is not only the primary concern of Navy men and women and their families, but also of the Navy's leadership. I am fully committed to improving it.

The access problem for dependents and retirees has arisen for three reasons. First is growth of the beneficiary population at the same time we have been revitalizing the Navy. Not only has the number

of uniformed personnel increased, but there has also been an accompanying rise in the dependent population. In fact, the number of Navy *families* has grown by nearly 63,000 since 1981. On top of that, the number of retirees continues to grow, thus adding greater requirements.

The second factor which has lessened the dependent and retiree access to Navy medical facilities is the necessary support to operating forces. With the growing size of our Navy, and with an increased emphasis on medical combat operations support, the intensity of readiness training and frequency of deployments for medical providers and ancillary staff increases. The result is a reduction of available services to shore-based beneficiaries.

The final reason for decreased access is a direct result of our quality assurance program. Efforts to ensure high quality care have resulted in a lesser number of patients seen by physicians. Unfortunately, we haven't been able to add more doctors to overcome this aspect of the access problem.

The health care access problem is a challenge and requires judicious allocation of resources to achieve a long-term solution. A simple infusion of personnel and money is not the answer if it does not sufficiently improve the health care structure to meet the needs of our medical beneficiaries. We should establish a system which will be better insulated from the changing circumstances we might face in the future.

One such effort to better serve Navy medical beneficiaries is our plan to supplement active duty personnel at our medical treatment facilities with civil service and contractor personnel. This will increase service to dependents and retirees and also improve wartime readiness by allowing more Navy medical professionals to focus on critical areas such as surgical skills. Additionally, in an effort to make physicians and other health care providers more available to patients, we have authorized 411 clerical positions in our various hospitals. More positions will be considered in the future as continuing studies dictate.

Another initiative to improve access to primary care is the NAVCARE clinics.

These clinics provide free primary care and prescriptions. After overcoming some initial growing pains, we now have four of these successful clinics in operation. Six more are planned for next year, and four more each year until we have 26 units on line. The six additional NAVCARE clinics in the budget for next year will provide 540,000 outpatient visits for dependents and retirees.

For years CHAMPUS has been the backbone of our ability to provide medical services unavailable at our medical treatment facilities. Shortcomings with this program have been identified and the Department of Defense is actively pursuing measures for improvement. Ways to reduce out-of-pocket expenses, minimize administrative burdens and expand available services are all being explored. We have recently begun a complementary program to CHAMPUS, the Joint Health Benefits Delivery Program. Under this program, civilian doctors will perform CHAMPUS functions at Navy medical treatment facilities. There is still a deductible charge, but your total out-of-pocket expenses will be lower than under CHAMPUS or in the private sector.

These planned initiatives have several benefits. Existing facilities will be more fully utilized, dependents and retirees will experience reduced expenses for health care, and accessibility to the health care system by dependents and retirees will be improved.

I have personally urged the chairmen of the appropriate Senate and House committees to consider our proposal for using contractor support as an interim step to help meet the current needs of the Navy's medical beneficiaries. This, for the reasons I mentioned earlier, will best serve everyone in the immediate future. I will continue to press for the resources which will best serve the health care needs of Navy men and women and their families. With your help, and the assistance of Congress, we can improve our medical care system to provide you better access to quality care.

I am eager to hear your comments on our initiatives. Feedback from you will be a valuable tool as we continue to make improvements to our medical care system. □

— Adm. Carlisle A.H. Trost

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64th YEAR OF PUBLICATION



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Front Cover: Neurosurgeons on staff and in residency at Bethesda Naval Hospital meet every morning to discuss the day's cases. See story page 26. Photo by PH1 Chuck Mussi.

Back Cover: USNS *Mercy* (T-AH-19) off the coast of the Philippine island of Luzon. The Mayon Volcano is in the background. See story page 18. Photo by PHC Chet King.

Navy Currents

Middle East task force

A new task force has been created to assume on-scene responsibilities for all U.S. operations in the Persian Gulf and North Arabian Sea.

Because of the increased presence and activities of U.S. forces in the area, Joint Task Force Middle East was established by Secretary of Defense Caspar Weinberger, acting on the advice of the Commander in Chief, U.S. Central Command and the Joint Chiefs of Staff.

Rear Adm. Dennis Brooks, formerly Commander Battle Force Seventh Fleet/Commander Carrier Group Five, was selected to head the new task force made up of personnel from all four services. □

Lodgings plus

The Navy has begun a test of a modified lodgings-plus for per diem computation. The test affects all temporary duty/temporary additional duty travel performed by Navy personnel on or after Aug. 1, 1987.

Meals and incidental expenses are now based on fixed amounts with no receipts required. The lodging portions of per diem is based on the actual daily cost of lodging not to exceed the amount allotted for the per diem area. All lodging costs must be substantiated by receipts.

This test will remain in effect until a DoD-wide lodgings-plus program is implemented. □

Helping Navy recruiters

Your sea stories could help bring talented people into the Navy. Navy recruiting's Hometown Area Recruiting Program will send you home to relate personal Navy experiences to your friends and neighbors.

HARP volunteers are on no-cost temporary additional duty orders and are not charged leave for the length of their HARP assignment. Leave, however, may be taken before or after

this temporary recruiting assignment.

After receiving command endorsement, interested personnel should submit their requests to: Commander, Navy Recruiting Command (Code 112), 4015 Wilson Blvd., Arlington, Va. 22203-1991. The 12-day, no-cost TAD period of HARP duty begins on a Monday and ends Friday of the following week. For further information, see your command career counselor. □

Overseas tours lengthen

Navy men and women in certain overseas locations whose projected rotation dates are after Oct. 12 of this year will serve longer tours. This includes people with overseas orders written after April 1, 1987.

The adjustment in overseas tour lengths was made after quality of life surveys indicated improvements in overseas facilities and conditions.

The change means sailors should anticipate serving (at about half of the locations) three years overseas if they are accompanied, and two years if unaccompanied.

For certain locations, the type of duty has also changed to preferred overseas shore duty (type 6) from overseas shore duty (type 3). Enlisted people receive sea duty credit for rotational purposes at type 3 duty stations only. Those who want to extend beyond their PRDs are eligible for benefits under the overseas tour extension incentives program, but their extension time will count as neutral duty.

For a complete list of overseas stations affected, see NAVOP 079/87. □

Aegis cruisers named

Secretary of the Navy James H. Webb Jr. announced the names of four new Aegis cruisers at the Marine Corps League's annual convention.

Hue City (CG 66) will be the first combatant ever to carry the name of a battle from the Vietnam war. Following the North Vietnamese

takeover of Hue City during the Tet offensive of 1968, U.S. Marines and South Vietnamese soldiers fought bitterly for more than a month to retake the old imperial capital.

"Hue City will cause all of us to remember the rewards of courage, and the sad legacy of commitments abandoned through the confusion of domestic politics," Webb said.

Chosin (CG 65) will also honor Marine battle participants in "one of the great moments in Marine Corps history," according to Webb. At Chosin reservoir during the Korean War, the First Marine Division fought their way out "under bitterly cold conditions, never losing unit integrity, never abandoning their equipment, their wounded, or even their dead," Webb said.

Two other Aegis cruisers will be named *Shiloh* (CG 67), for the 1862 Civil War battle in Tennessee, and *Anzio* (CG 68) to honor those who landed at Anzio, Italy, in World War II. □

Toll-free service numbers

The Naval Military Personnel Command now has five new toll-free numbers to assist Navy people in several personal service areas.

For questions on benefits eligibility of incapacitated dependents, former spouses, widows and 100 percent disabled veterans, call (800) 443-9297 outside the state of Virginia. In Virginia, call (202) 694-3355.

For questions concerning prisoners of war and those missing in action, call (800) 443-9298. In Virginia, call (202) 694-3338.

Retirees can receive assistance from the retired personnel support branch by calling (800) 255-8950. In Virginia, (202) 694-3197.

For assistance on how to resolve DEERS enrollment eligibility problems with the Dependent Dental Plan, contact the Dependent Dental Plan Program Office at (800) 255-4919. In Virginia, (202) 694-3356.

The number for information about your direct deposit paycheck printed in the July '87 *All Hands* has changed. The new number is (800) 346-3374. □

ALL HANDS

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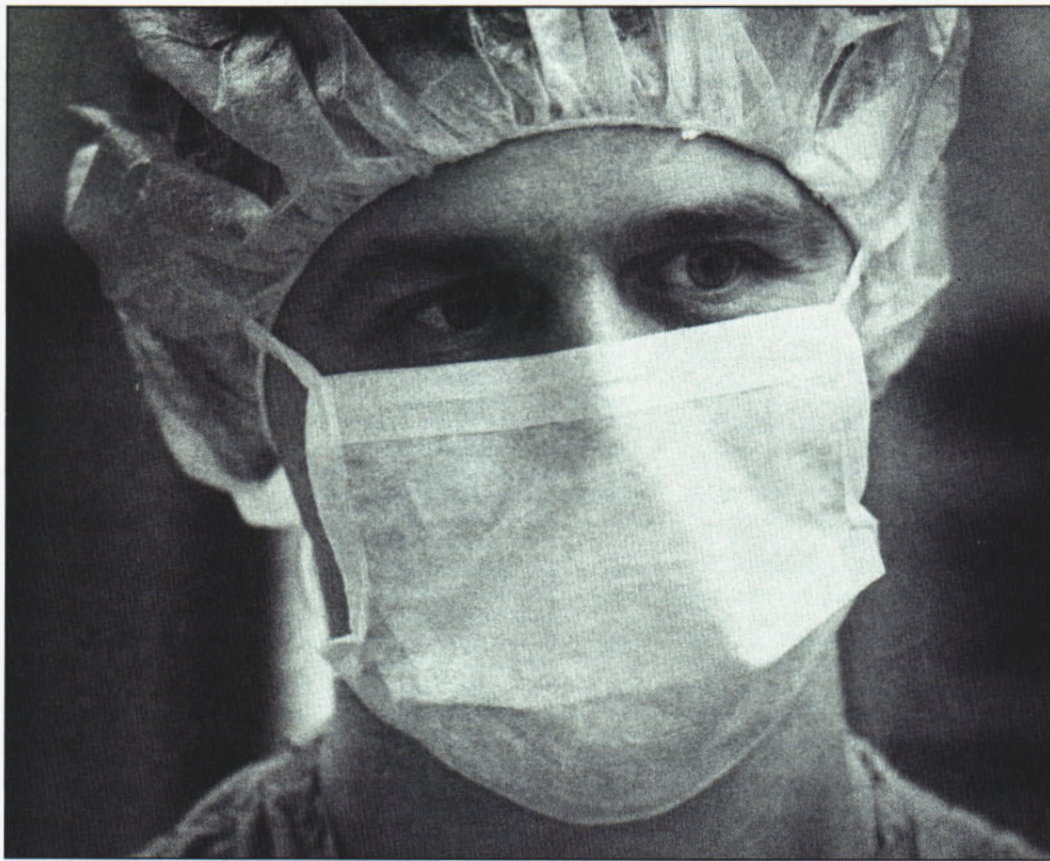
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A look at those who look after us

“The Navy takes care of its own.” We all expect this saying to hold true for the sake of our shipmates and ourselves. One of the most important ways in which the Navy cares for us is through Navy medicine. To find out how Navy medicine works, to answer questions about how it can work better and to learn more about some of the Navy men and women who have the very special job of serving the fleet’s health needs, All Hands has prepared this special issue.

We have collected stories from around the Navy, sent writers into hospitals to look over surgeons’ shoulders and talked to patients and doctors. The result is a comprehensive look at the Navy medical community — who runs it, who works in it, who is served by it and what it can do for all of us.

Vice Admiral Zimble Surgeon General of the Navy

To fully understand any organization, it helps to start at the top. So that All Hands readers may better understand the Navy medical community — how it works and how it plans to meet the health care needs of Navy men and women, now and in the future — All Hands assistant editor JOCS Jeannie Campbell visited Navy Surgeon General Vice Admiral James A. Zimble in his Medical Command office in Washington, D.C.

All Hands: You've been the Surgeon General of the Navy since 1 July. What do you think of the job so far?

Zimble: Well, I find it a very challenging job and it's only a half-day long — 12 hours. I find I have difficulty emptying my in-basket by the end of the day and that there's a great deal to occupy my time. I certainly don't feel I'm on the public dole.

All Hands: What do you see as your top priority?

Zimble: My top priority is to treat a patient who is anemic. That patient is Navy medicine. Navy medicine has been under-resourced for a long time and I'd like to equate that to a person who has had chronic, iron-deficiency anemia. An anemic patient needs two things: first, an immediate blood transfusion and second, some good, strong iron-rich nourishment and maybe a little extra iron supplementation in their diet.

What I mean by this analogy is that we've got to — first — get more people. And not just physicians, but personnel from across the board in our officer and enlisted communities. We need more people so we can adequately utilize the

facilities that we have and thus better meet our patients' needs. It's difficult for an organization to *grow* quickly, as we need to, so I use the blood transfusion analogy when referring to the immediate, interim measure of contracting out for much of the care required. Secondly, we need to do more, in the long term, with the folks we *do* have in uniform. That long-range problem requires a long-range

solution, like a dietary supplement — it takes time, but eventually it works.

All Hands: During the last few years, there's been a lot of criticism of Navy medicine. We read about the horror stories — of the incompetent heart surgeon who causes the deaths of several patients, for example. As the Surgeon General, what are you doing to correct these problems?

Zimble: Well, first of all, there's a misperception. The media are doing their job. But one or two horror stories look like many — the same cases are reiterated over and over again. The fact is that we are treating more than 14 million outpatients, a quarter of a million inpatients, and making 30,000 deliveries of babies. That's the real news, and facts that most people don't know or understand.

We do an amazing amount of good medicine, but unfortunately that doesn't sell newspapers. I consider the Billig case serious, but isolated, and it's behind us now. We had at that time and we have today, good quality assurance in Navy medicine. The process to control these problems is there. We need to be sure that it's appropriately monitored at all



Surgeon General of the Navy

times and that we attend to our quality-assurance process. It is working and it is working successfully. Navy medicine is the envy of the civilian community.

All Hands: Many Navy men and women view the Navy medical community as one big, uncaring bureaucracy. Is that a real problem or is this another perception problem?

Zimble: It's a problem of perception. In many cases it is the result of overwhelming demands placed on caring but frustrated people who, as their energies are expended, become more frustrated, and their abilities to reflect their true caring personalities are put under a lot of stress. Yes, we have a bureaucracy. Yes, we *can* work the bureaucracy better than we have and yes, we *can* emphasize more that we care for our patients.

One of the things that I feel that we haven't done well in our organization is care for our own Navy medicine people. We demand that our people give the very best care at all times to their patients. If we want them to do that, as well as they can, all the time, then we are going to have to demonstrate that we care for them as much as we expect them to care for others.

All Hands: Why does it seem that sometimes sailors can't get medical care until there's an emergency?

Zimble: Access is our biggest problem. People in a hurry call us for an appointment and get a busy signal. It's very frustrating and it certainly seems uncaring — that beep is a very uncaring beep. We can improve that with more telephone lines. Then we will get rid of the busy signal but we'll still have to tell many people, "I'm sorry, our appointments are full, but we can schedule you somewhere in the future." Those things tend to broaden the level of dissatisfaction because, once again, access isn't there — due to the lack of resources. Our number one priority has to be quality care, and we will not compromise that quality when we increase quantity. For that reason we are looking to contract-

ing. For that reason we are pressing our demands for growth in end strength. But these demands come at a bad time, a very austere time as far as Congress is concerned. Still, we have to make our case for the required medical community end strength.

All Hands: What do you think about the new dental plan?

Zimble: I think it's terrific. Dental care is necessary for our people because dental health is important to their overall health. Unfortunately, we don't have the resources to care for *all* beneficiaries eligible for space available dental care and therefore the new dental plan is a big help. It will be a shared-cost plan, but I think it's a step in the right direction. Dentists who participate in the plan are screened and monitored by the contractor, who has a major investment in keeping the patients satisfied. So the economic pressures are there to keep the patient satisfied. Further, it is the contractor's plan to assess the system by asking our beneficiaries for their input regarding the care they've received.

All Hands: The Navy has recently opened four new NAVCARE clinics, manned by civilian doctors. How are these clinics doing?

Zimble: They got off to a typical start for a new program. They didn't quite meet the needs of our patients at first, but they're doing better now. We're renegotiating contracts to provide those things that were not initially provided, so that we can meet the needs of our patients. They've seen well over 100,000 people at the new clinics. The initial complaint was about long waits for treatment. Those problems are being corrected.

We are looking at the locations of the clinics and the cosmetics of the clinics to ensure that we are providing an appropriate atmosphere for the treatment of our patients.

Some of the clinic personnel specialty mixes have also been changed to better meet the needs of the patient population.

If I were a hospital CO, I would welcome a NAVCARE clinic with open arms, because a hospital can very quickly be overwhelmed by the volume of what I would call urgent minor care.

We need the NAVCARE clinics to handle the non-specialized cases and then refer the more complicated cases back to our facilities.

We're hoping to have six more NAVCARE clinics by next fiscal year, a total of 26 overall. Whether we will need that many has yet to be determined. We may want to modify that number as time goes on. Hopefully, we'll grow just as much as we need to act as a referral base back



to our hospitals and take primary care load off our hospitals.

All Hands: In Washington, D.C., as in other major metropolitan centers having a large Navy population, there are complaints about how long it takes for dependents to get an appointment. Is there anything being done to improve the responsiveness in providing Navy care to our dependent and retired community?

Zimble: Responsiveness boils down, again, to resources. We cannot increase our responsiveness to the point of eroding the quality of the care. Again, we'll look at contracting. We can contract for

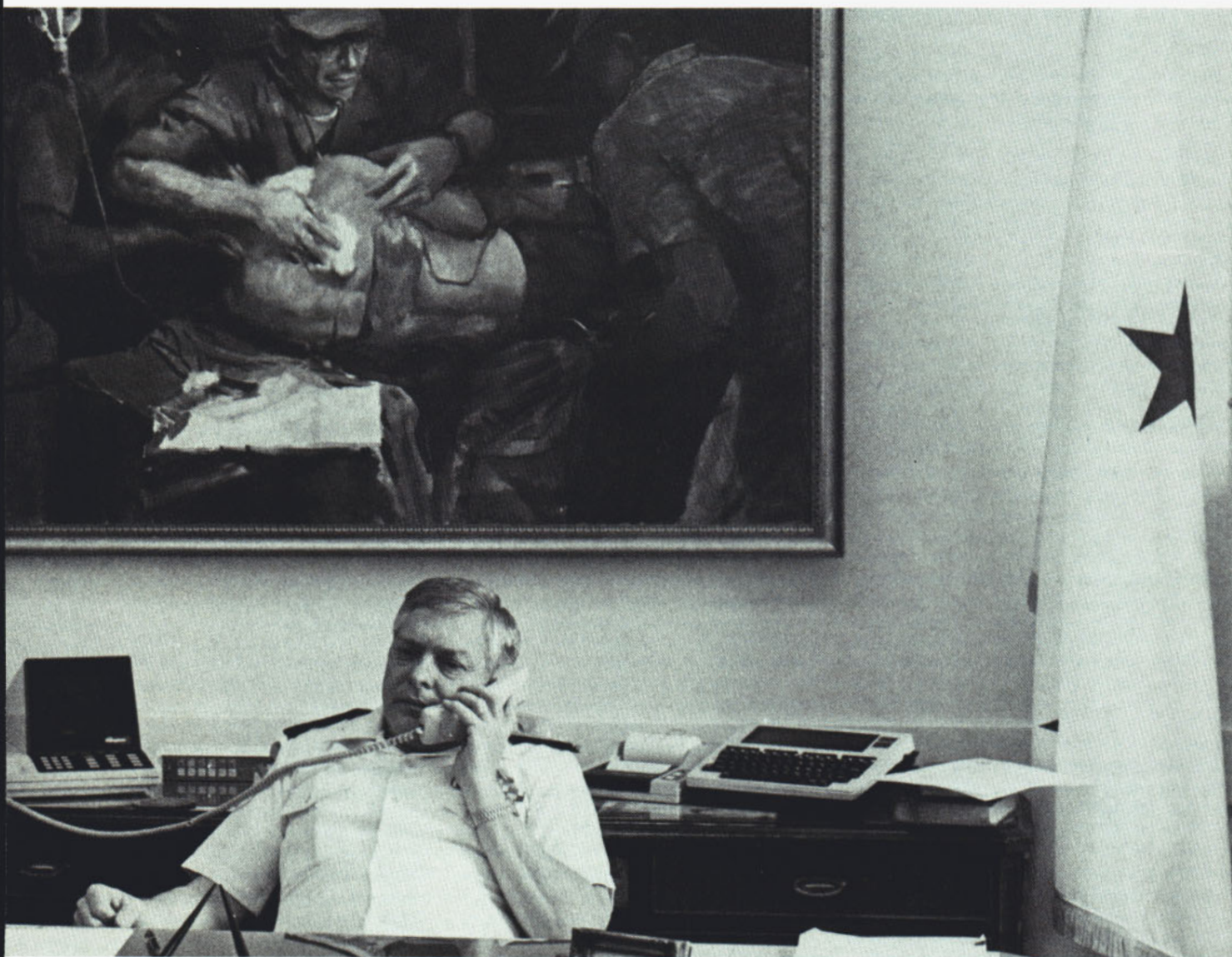
individual providers or for certain support services or for services in general. We're looking at that across the board in all of our facilities as an interim fix. I still feel the ultimate solution is going to be "growing" more Navy medical department officer and enlisted personnel. We need to grow by almost 20 percent. We need 9,000 more people.

All Hands: You've already addressed some general questions about manning levels in the medical community. How is the manning level for medical specialties?

Zimble: In certain specialties, we have significant shortfalls. I am undertaking

two major efforts to overcome these problems. One is a recruiting effort to fill our increased authorized billets; the other is to find fiscal ways and means. But even more important is the need to retain the good people that we have. We can retain them only if we demonstrate we care for them: give them the support they need — clerical support, technical support and adequate spaces.

We haven't done a really terrific job in persuading some of our enlisted folks to go to "C" school — we are not meeting our "C" school quotas. There are some great opportunities for getting specialized education.



Surgeon General of the Navy

All Hands: Why did the USNS *Mercy* go to the Philippines? Why not to Norfolk or one of the other CONUS areas with high Navy concentrations?

Zimble: First it needed to be tested. This is a unique hospital ship. We have never had, nor does there exist anywhere in the world, a hospital ship with the capabilities of *Mercy* — one thousand beds, 12 operating rooms and an ability to perform high-flow/high-volume casualty care in short order. We needed to put it through its paces and ensure that it lived up to our expectations. The Philippines offered us that opportunity. It gave our people a chance to be exposed to tropical diseases and other types of diseases not readily extant in this country.

The *Mercy* trip was not just a Navy effort. We had personnel from three military services and Public Health Services, both active and reservists, and the Military Sealift Command. We used the trip as an ideal training opportunity for a significant number of people.

All Hands: How do you feel the ship and its staff performed?

Zimble: They performed beyond our wildest expectations! We were able to show the best face of the United States military establishment in an important foreign country. We took care of over 60,000 patients, performed over 2,000 surgical procedures and visited numerous ports.

All Hands: Are we going to be seeing dramatic changes in the way Navy health care is administered in the future?

Zimble: The first dramatic change will be an increased effort to get adequate personnel to fully staff our facilities so we can take full advantage of our considerable investment in them.

Beyond that, I think we are going to have to do CHAMPUS smarter. There *will* be CHAMPUS reform. It's got to come. We have to very prudently use the leverage that comes from the large number of patients our treatment facilities will never be able to handle. Either we'll



do that on a service-wide basis or we'll see it being done DoD-wide. It will get better. Just as our civilian counterparts in corporate America are starting to recognize the need to be prudent in their purchase of health care — we have to realize that we have great buying power. We just have to use it properly. CHAMPUS is 22 years old and we've had no major changes. We're buying care the same way we did in the '60s and medicine has gone through some significant changes since then.

All Hands: The huge increase in the number of malpractice suits and, in some cases, the size of the awards, has drastically altered the whole private medical system. Can the same thing happen in the Navy medical community?

Zimble: Yes, it can, and I think we have to be very careful and not let it happen. We have not seen a burgeoning of suits in the last few years. As a matter of fact, we have seen fewer suits since 1984 — there has been a decline in the numbers. The awards in many cases have gone up however, and that's disconcerting.

I don't think we will find medical quality assurance in a courtroom. We need to avoid having to practice defensive medicine. We need to employ our full energies toward the best interests of our patients and their care and not have those efforts diluted because we are con-

cerned about lawsuits. The threat of a lawsuit does not make a doctor practice caring any better.

All Hands: How big is the problem of AIDS in the Navy?

Zimble: The problem of AIDS in the Navy is similar to the problem of AIDS in the civilian sector. But I think we will see the problem lessen because we are screening accessions in the Navy. It's a terrible disease that right now is limited in terms of the population. Roughly, we are finding positivity in about two per thousand, Navywide.

All Hands: What would you say to sailors around the world about AIDS?

Zimble: I would say that they should listen carefully to the Surgeon General of the United States when he suggests safe sex — AIDS is, in part, a sexually-transmitted disease. It is also transmitted in another high-risk group, the IV drug user. If we can prevail upon our sailors and Marines to live up to the tenets of our service regulations, then the risk will be minimal.

All Hands: What advice do you have for prospective retirees and their families regarding Navy medical care?

Zimble: By statute they are at the bottom of the priority listing for space available at a medical treatment facility. They have *never* been a low priority in overall care. In fact, they are entitled by statute to medical care. If they can't get in a direct care system, we need to look at the alternative source, which is CHAMPUS. Since CHAMPUS is a cost-sharing mechanism, my advice to those who participate in CHAMPUS is to have adequate supplemental insurance to minimize the cost-sharing.

I've got to tell you that I want to take care of as many retirees and their dependents as possible. I want to do it not only because I think it is the *right* thing to do, not only because I think we have a moral and implicit obligation to care for these people — I want to do it for other important reasons. Our physicians, nurses,

dentists, corpsmen, dental techs, allied health sciences — all of those folks need to be proficient and skilled in what they do. They need to maintain those skills. They need to maintain state-of-the art proficiency in both their mental and manual skills. We achieve that by treating patients. That's how we stay prepared, should we need to go to war. The better able we are to take care of our patients in peacetime, the more able we are to demonstrate our preparedness, which, in turn, makes it less likely we will ever have to go to war. We in the medical community can be a significant deterrent.

Not only do we need the full, broad case-mix of people who we care for to keep our skills honed, we need them to maintain the most important recruiting and retention motivation that we have in military medicine, and that is our graduate medical education program.

For all these reasons — to maintain our skills, to maintain our military preparedness, to maintain our educational programs so that those skills are available in 10, 20, 50 or 100 years — we need the patients and we need them across the full spectrum. From infants to retirees, everyone benefits.

This is our goal, providing we get the resources. We need to convince those who hold the purse strings that this is the right thing to do.

All Hands: Where do you want Navy medicine to go in the next five or ten years?

Zimble: I want it to flourish and overcome its current anemia. I want it to return to a full, red-blooded, healthy, caring organization that can meet the needs of all of our patient populations and be prepared to support our forces in time of combat.

All Hands: I understand that you're not only the Surgeon General of the Navy, but also the Surgeon General of the Marine Corps.

Zimble: You bet. Navy medicine serves two military services. While our total population ratio is about 3-to-1

Navy over Marines, the majority of our patients will come from the Marine Corps if we go to war, so we have an obligation to both services.

All Hands: If you could spend five minutes talking to every patient in the Navy medicine system, what would you tell them? And as a follow-up, if you could spend five minutes talking to every Navy doctor, what would you tell them?

Zimble: I'd tell them both about the same thing. I'd go right back to the family issue. I would make sure that they rec-

ognize that we're talking about family and we're talking about the most important reason we have Navy medicine — to serve a war-time Navy and Marine Corps. We design for war, modify for peace. Our objective is the same as everybody else who wears the uniform: to be sure that we prevail if we ever have to take on some other military force.

I want excellence to be our descriptor. Charlie Golf One — "We are standing by to assist" — is our byword. □

— Photos by Russ Egnor



'Top Doc'

Flight surgeons decide who soars — and who sits.

Story and photos by Cpl. Jeri Van Duzen

Traditionally, aviators have viewed flight surgeons with a wary eye. After all, these guys in the white coats can get you grounded.

Navy Lt. Rick Senter, one of the Navy's newest flight surgeons, aims to change that traditional view. Assigned to Marine Medium Helicopter Squadron 166, MCAS Tustin, Calif., Senter believes that the more a physician tries to understand a flyer's psyche, the more likely that flyer will come to the doctor with problems.

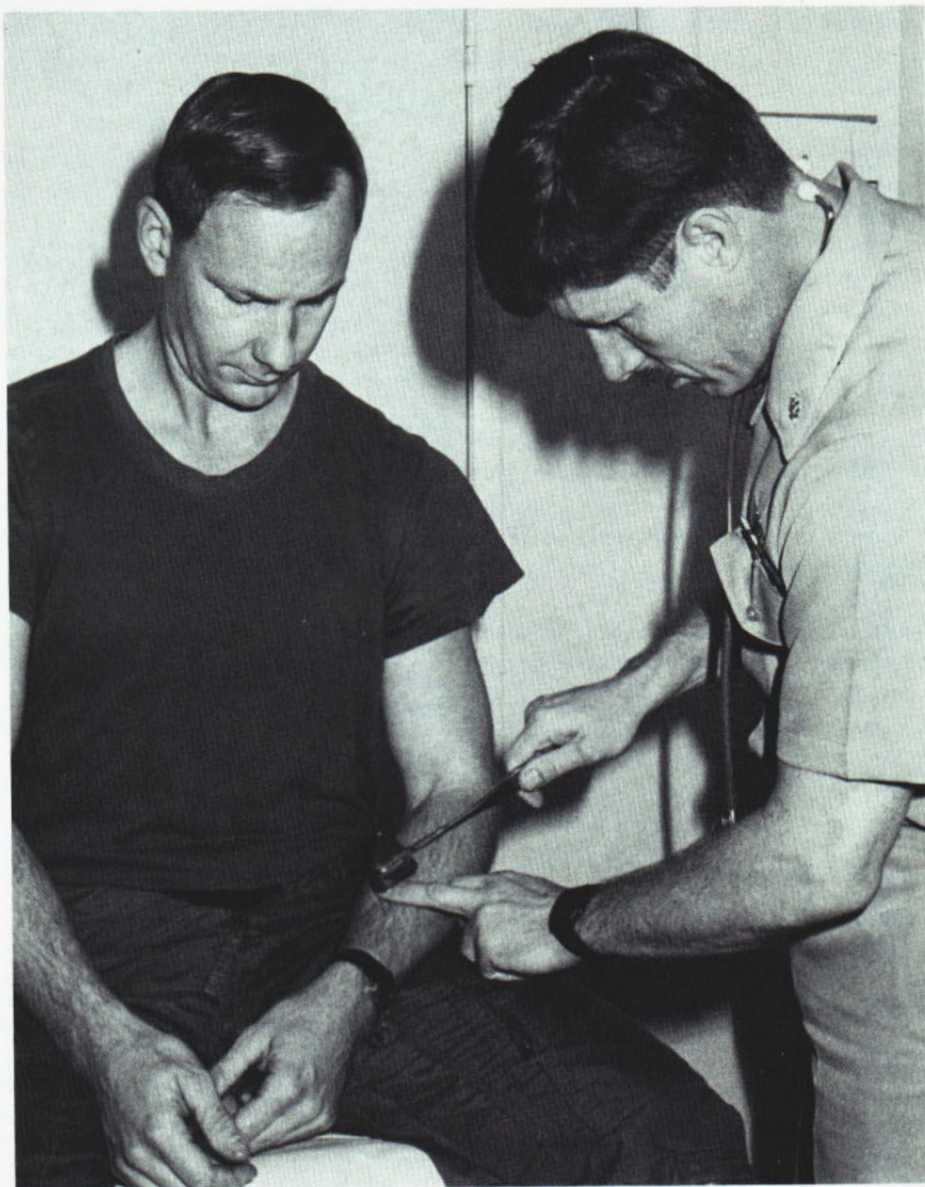
Overcoming this built-in aversion that fliers seem to have toward doctors is not easy, according to Marine 1st Lt. Tom Stewart, a helicopter pilot stationed at MCAS El Toro.

"It can become an 'us vs. them' situation," Stewart said. "And it's frightening to us pilots because we have no control over our eyesight, heart rate or blood pressure."

This aversion often begins at flight school, where pilots undergo a week-long battery of tests at the Naval Aerospace Medical Institute. Those arduous tests are known as the "NAMI whammy," and they weed out candidates not physically qualified as pilots.

"NAMI whammy is a joke, but it's a morbid joke to those who don't make it," Stewart said.

Lt. Rick Senter tries to overcome the "us vs. them" attitude of many pilots toward flight surgeons.



Senter says he understands and makes an extra effort to be sensitive to flyers' perceptions of a flight surgeon's role.

"Flight surgeons are often seen as NAMI's tentacles, looking to grab those who've slipped through," he said. "It takes a while for fliers to realize we're not 'NAMI Nazis.' To get over that stigma, it's important for doctors to spend time in the squadron and get to know the aviators personally and professionally."

"Flight surgeon" is more than just a title. Senter and his counterparts have completed two months of flight training at NAS Whiting Field. The doctors usually have their choice between rotary- and fixed-wing aircraft. Although Senter selected fixed-wing, when he arrived at El Toro he was assigned to HMM 166 and has no regrets. "Working in the rotary-wing community offers me a broader experience," said Senter, dubbed "Top Doc" by the squadron. "I really respect these guys a lot and feel very lucky to be the squadron flight surgeon."

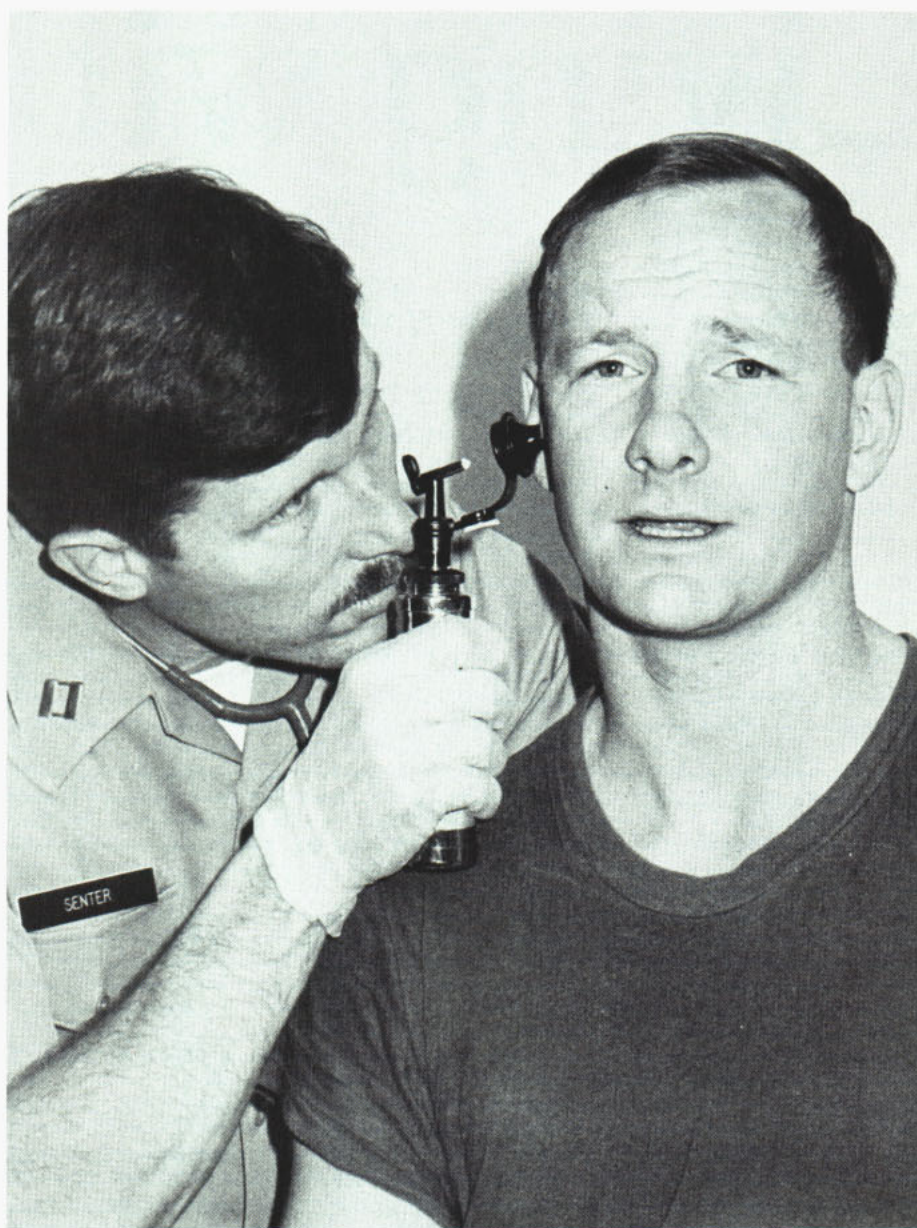
"Above all," Senter added, "we have to realize that lives are at stake. If we're too quick with the 'down chits,' we'll destroy the fliers' trust. And when they stop coming to us, things start to deteriorate in terms of safety."

The aviation environment is especially taxing for physicians and pilots alike. "It's an intense environment where top physical conditioning is required to fly safely," Senter said.

"Our basic philosophy is to provide preventive medicine — to anticipate problems and keep those problems from becoming 'safety of flight' issues."

Special deployments are times when the physicians have to be especially alert. "The operations tempo is much higher on deployments," Senter said. "People work long hours, eat irregular meals, sleep in tents with the wind and dust blowing through or on rocking ships where their rooms are right under the flight deck. Those are all stresses that could become safety factors."

One way Senter deals with the problems of stress among fliers in his com-



mand is through a newsletter he writes called "Phrog Phacts." In it, he deals with such topics as nutrition, stress, low-level flying hazards and alcohol abuse. "Phrog" is the nickname for the CH-46E *Sea Knight* helicopter flown by the squadron.

"Most pilots are active in their own physical fitness programs, so Phrog Phacts supplements their other sources of information," Senter said.

Whether flying, training, counseling or publishing newsletters, Senter epitomizes dedicated flight surgeons everywhere.

Flight surgeons seek to keep health problems from becoming safety problems.

"The longer I am a flight surgeon," he added, "the more insight I can develop about what it's like for a pilot in the cockpit. Right now, I am right where I want to be." □

Van Duzen works at the Joint Public Affairs Office at MCAS, Tustin.

Living with fear

Editor's note. This is a true story about a Navy petty officer who has AIDS. His name has been changed to protect his identity. Who he is or how he got the AIDS virus is not important to this story. What is important is what he has to say about AIDS to the rest of the Navy.

For 14 years, John, a 34-year-old U.S. Navy petty officer, battled one life-threatening disease: alcoholism. Now a recovering alcoholic, he finds he is once again fighting for his life, but this time the odds are really against him. John has been diagnosed as having AIDS-Related Complex.

The AIDS virus can be likened to a pyramid. The victims at the top have developed full-blown AIDS. People with ARC fill in the middle of the pyramid. There are 100,000 to 200,000 people in the nation in this middle category. At the base of the pyramid are people who do not have the disease, but who have been infected with the AIDS virus. There are between one and two million of these cases in the country.

According to The Centers for Disease Control in Atlanta, of the million and a half people infected with the virus, 20 to 30 percent will develop full-blown AIDS within the next five years. Another 30 percent will develop some of the symptoms of AIDS. In other words, about half of the people exposed to the virus will develop AIDS or some of its symptoms.

"I wasn't really shocked when I found out I had tested positive," John says. He admits he hasn't lived "the life of a saint." He says, "I gambled and lost, but it still came as a slap in the face. I always assumed my health was fine." Now on top of his problems with alcohol, John

must deal with the prospect of AIDS.

By going public with his problems, John hopes to get his story out to the rest of the Navy so that others might learn from his mistakes. "People don't get into Alcoholics Anonymous drinking too many iced teas, and people don't get into my situation by practicing safe sex."

John admits though, that telling his story to *All Hands* is also something he's doing for himself. "I needed to get some of this out, for my own well-being and peace of mind."

John is not alone. To date, 82 active duty sailors and marines have been treated for AIDS. Another 105 sailors and marines have been iden-

"The Navy's been good to me. That saying that 'the Navy takes care of its own' is true. I have nothing but praise for the doctors and corpsmen who take care of me."

tified as having ARC and an additional 1,509 sailors and marines have tested positive to the HIV virus.

With John's help, perhaps each of us can gain a better understanding of the disease and what can happen if you gamble with your life — and lose.

Each time he goes to the medical facility to determine his fitness for duty, it's like walking on a razor's edge. Two weeks of anxiously

awaiting test results — results, which like a judge passing a sentence, say “life” or “death.”

“I think they were kind of surprised at the results of my latest tests,” John says. His doctors had been expecting the worst, but he was given a reprieve as his T-cell count climbed back up. “It’s like playing Russian Roulette,” John says. His biopsy came back negative for Kaposi’s sarcoma, a form of cancer. This time the gun didn’t go off, but next time, who knows, the chamber may not be empty. One of the many “opportunistic” diseases common to AIDS victims could develop. “I’m glad I seem to be holding my own right now,” John says.

“The Navy’s been good to me. That saying that ‘the Navy takes care of its own’ is true. I have nothing but praise for the doctors and corpsmen who take care of me.” And it’s not just the medical people, it’s also his command.

Although his co-workers have been supportive, he says that there’s sometimes a problem dealing with his situation on the job. According to John, he’s been up-front with the people at his command, choosing to tell them a long time ago about his problem.

“I would come in on some days and be the king of the high seas. But then I would go through a major mood swing and get very despondent.” He feels the people he works with don’t need to be subjected to his anxieties and despondency. “I’ve just got to take one day at a time.”

John joined the Navy seven years ago in an effort to get his life in order and make something of himself. It seemed to him that he had reached a dead end, changing from one job to another every six months. “Until I joined the Navy, I had never completed anything that I’d started. The Navy was the first time I had ever stuck with anything.”

Now his life is in limbo again. Forced to play

“You never know how much time you have left. It’s like an hourglass but you can’t see when you’re going to run out of sand. This disease comes on so fast, one day you’re fine, then two or three days later you’re as good as dead.”

a waiting game, he lives with uncertainty. He may or may not develop AIDS. If he does develop AIDS it could be in months or it could take years.

Both AIDS and ARC victims have to learn to contend with the debilitating and frustrating unpredictability of the disease.

“You never know how much time you have left. It’s like an hourglass but you can’t see when you’re going to run out of sand. This disease comes on so fast, one day you’re fine, then two or three days later you’re as good as dead.” In John’s case he wanted to go back to sea, now that’s impossible. With his service record flagged almost a year ago as a medical hold, John feels he doesn’t have a future in the Navy. “The Navy’s been a good part of my life,” but, unable to go to sea, he thinks his chances for advancement are slim.

Because John has tested positive, he is restricted to within a 300-mile radius of one of 19 Navy medical facilities that are set up to handle patients with AIDS-related problems.

He’s decided it’s time to get out of the Navy and move on to something else. However, like the frustrating unpredictability of the virus itself, the question of who will pay the medical bills if

he gets out is also uncertain in his mind.

Meanwhile, one of his biggest concerns is his family's reaction. He does not want to become a burden on them. In the final stages of the disease, AIDS puts people through the tortures of hell. John doesn't want his family to have to watch him dwindle away to nothing.

"My mother is going through major denial. She doesn't want any of the neighbors to know. It's one of those things you just don't talk about." John's mother doesn't want to believe that her son has ARC. "If she does admit there is something wrong with me, she still says it's cancer. That's her way of coping," John says.

His family members are not the only people who have problems dealing with John's illness. It's not every day someone who has the AIDS virus comes forward and is willing to talk about his condition — particularly when the very word brings fear.

Loneliness is one of the highest prices John

"You get AIDS and you've got it for life. Take care of your own health as best you can. Don't do drugs. Practice safe sex."

has had to pay. Daily there are stories in the newspapers about men, women and children who have become society's outcasts because they carry the virus. He says he wants other sailors to listen to his story. He's learned lessons the hard way that perhaps others won't have to learn.

"You get AIDS and you've got it for life. Take care of your own health as best you can. Don't do drugs. Practice safe sex," he advises. "Don't wait till the horse has run away to close

the barn door. It will be too late — you'll lose if you gamble. You're playing with a time bomb if you don't have safe sex.

"AIDS is like a sleeping dog. Maybe you'll find symptomatic results within six weeks after a night on the town, but I doubt it. It's not like coming down with gonorrhea where they can give you a shot and it's gone. *I wish it was that simple.*"

John is not just talking to homosexuals but

"Every time I read about another person dying from AIDS I get more and more despondent."

also to bisexuals and heterosexuals. "You don't know who's messed around with whom and who's done what to whom.

"It's real sad to see babies born with this disease," John says. "Babies who had nothing to do with it and didn't have the power to choose. Or the wife or the husband, who gets AIDS from their spouse. I think that problem is going to be magnified in the near future."

Even though the statistics still focus on a select group of people, drug users and homosexuals, John doesn't think AIDS is going to be limited to that group forever.

There aren't any simple answers to the problem. John has had the opportunity to reflect on the disease and what it's done to him and the rest of society.

"It's got a lot of people scared, including me. Justifiably scared." But for John, out of that fear comes one clear lesson: "If you don't care enough about your own life, at least care enough about someone else's life to take the proper precautions.

"I've gone to total sexual abstinence since finding out that I was HIV positive," says John, who still has alcohol problems. "For me, alcohol can easily become an escape method. It doesn't take the place of anything, but it helps you forget, until the next morning, then the problems are there again. That's a copout — to keep drinking, knowing that your condition gets worse with the presence of drugs or alcohol."

He has strayed from a support group for alcoholics who have AIDS, ARC or HIV positivity. In the short time he was associated with the group, he saw two people die. The mortality of friends is something that is hard for John to face. "Every time I read about another person dying from AIDS I get more and more despondent," he says.

"One guy told a close friend right before he died something that has really stuck with me," John says. "Although in intense pain, he declined mass doses of morphine. He said, 'I wouldn't be able to pray and I have to pray because I've got to make sure I'm ready to go home.'"

John talks a lot about his own mortality and

"I guess it goes back to the old condemnation of myself. Sometimes I want to believe that this is God's final wrath."

his relationship with God. "I'm still mad at God," he says. But he knows he's going to have to make peace with God, for his own sake. "Everybody that has had AIDS and achieved any amount of serenity during the time they had left on earth made peace with God, or that higher power."

John believes we're all searching for that

serenity — that making peace with God before our time on earth is up. He grew up as a catholic, but for the last 12 years he has not been actively practicing his religion.

"I guess it goes back to the old condemnation of myself. Sometimes I want to believe that this is God's final wrath." Other times he admits he's angry at himself. "I really wonder if we do have the power to choose our own destiny or what we become."

"It's the waiting that's the hardest."

His mother sometimes calls him "Mr. Macho" because, as he says, "I try to deny anything is wrong with me. Be tough. Put up defense mechanisms. Hopefully, I'll learn to let them down."

For John, the future is unknown and filled with unanswered questions — terrifying questions. The only certainty is today. Tomorrow is not something he can count on. "I want to stay as productive as possible. I'm still getting my paycheck." In the meantime, all he can do is continue to go to work and to his meetings: once-a-week trips to the hospital where he meets one-on-one with a Navy psychologist; weekly meetings with his alcohol after-care group; and most crucial of all, his physical evaluations, where he learns about the progress of his body's battle against AIDS. John knows it is a desperate battle.

"It's the waiting that's the hardest." □

— Story by JOCS Jeannie Campbell.

As of September 1, 1987, the Centers for Disease Control revised their definition of AIDS. Under the new definition, individuals having been formerly classified as having AIDS Related Complex are now classified as having AIDS. This broadening of the AIDS definition was brought about in an attempt to provide a more accurate accounting of the scope and impact of the AIDS epidemic in the United States. — Ed.

The KILLER

Acquired Immune Deficiency Syndrome, or AIDS, is a deadly, infectious disease for which there is currently no known cure or preventive vaccine. This disease crosses all race, age and sex barriers. No one is immune. The five-year mortality rate is 50 percent and once a person is infected, he or she remains infected. According to the U.S. Surgeon General's office, an estimated 1.5 million people in the United States have been exposed to AIDS and that number is expected to grow. Of those diagnosed as having been exposed to the virus, more than 40,000 in the U.S. alone are known to have AIDS and of these, about half have died. That number, too, is expected to grow.

The disease is brought about by a virus — human immunodeficiency virus (HIV). This virus attacks the body's immune system and damages its ability to fight other diseases. As a result, a person becomes vulnerable to infection by other viruses, bacteria, parasites, and malignancies that could lead to life-threatening illnesses such as cancer, pneumonia, or meningitis. There is also evidence that the virus may also directly attack the nervous system and cause brain damage.

HIV can be passed from one person to another either during sexual contact (heterosexual or homosexual) or by sharing intravenous drug needles or syringes. There is no danger of contacting the virus through normal, casual, social contact.

In sexual contact, a person may get the virus through contact with an infected person's blood, semen and possibly vaginal secretions. The virus enters the blood-

stream through the rectum, vagina or penis. Small tears in the surface lining of the vagina or rectum, that cannot be seen by the naked eye or felt, may occur during intercourse. These tears give the virus an opening to enter the bloodstream. The virus may enter the bloodstream via the rectum without obvious tearing of rectal tissue; this is considered the main reason male homosexuals have been at higher risk than other segments of the population. About 70 percent of AIDS victims in the U.S. are male homosexuals (or bisexuals). This percentage will probably decline as heterosexual transmissions increase.

The risk of infection increases not only according to the type of sexual activity but also with the number of different sexual partners.

For drug users who share syringes, the virus is transmitted by contaminated blood left on the needles. This contaminated blood is injected into the new victim with the reuse of the dirty syringe.

The most certain way to avoid getting the AIDS virus and to control the spread of the disease is for individuals to avoid promiscuous sexual practices, to maintain mutually faithful monogamous sexual relationships and to avoid injecting illicit drugs. Other than these precautions, the next best protection comes from the use of condoms during intercourse. Condoms have failed in some cases, however, possibly due to varied sexual practices.

It should also be mentioned that blood transfusions prior to 1985, before medical professionals knew how to screen blood for AIDS, may have been the

cause of infection in certain individuals. Routine testing has now made blood much safer.

For many people who are in the early stages of developing the disease, there are no apparent symptoms of infection. In other cases, there may be symptoms that a person has AIDS. These may include a persistent cough and fever in conjunction with shortness of breath or pneumonia. Multiple purplish blotches and bumps on the skin may also be signs. If the disease has attacked the nervous system, it may take years before the symptoms develop. These may appear as subtle memory loss, partial paralysis, loss of coordination, or more severe mental disorders. Such symptoms may occur alone or with those previously mentioned. Only a physician can make a correct diagnosis.

There is also a condition caused by the AIDS virus, referred to as AIDS-Related Complex, or ARC, in which the patient tests positive for AIDS exposure and has a specific set of symptoms that are often less severe than those associated with actual AIDS. The symptoms of ARC include loss of weight and appetite, fever, night sweats, skin rashes, diarrhea, general tiredness, swollen lymph nodes or lack of resistance to infection. These may also be symptoms of numerous other diseases and, again, only a physician can make an accurate diagnosis.

The Department of Defense is currently testing all military personnel to detect the presence of antibodies to the AIDS virus. The presence of HIV antibodies indicates exposure to the AIDS virus; it does not necessarily mean the person has, or will get, ARC or AIDS.

in our midst

This testing is necessary since the armed services act as their own blood bank during a national emergency. New recruits are also being screened not only to safeguard their own health but to protect those already serving.

If an active duty man or woman is diagnosed as having been exposed to the AIDS virus or as having ARC, it is the Navy's policy to treat that person as having a medical condition; the diagnosis is not grounds for disciplinary action. An individual on active duty testing positive for HIV is referred to one of four centers for treatment and observation. These centers are the Naval Hospitals at Bethesda, Portsmouth, Oakland and San Diego.

While at one of these hospitals, the patient is given a medical evaluation over a two-week period. The patient is then placed into a certain medical class, depending on their laboratory and clinical status including an analysis of the progress of the disease. Classes 1 and 2 with antibody positivity represent infection only, not disease, and those personnel (if found fit for duty) are retained on active duty. Classes 3, 4 and 5 are different levels of ARC, while Class 6 is AIDS. Generally, classes 3 through 6 are placed on the temporary disability retired list. Personnel on the TDRL are eligible for continued Navy medical care.

Patients not sick enough to remain bed-ridden in the hospital are placed in a medical holding company. While in that company, these patients will be given work assignments appropriate to their physical condition and rank.

The discharge of AIDS patients from

the Navy is determined after each patient is evaluated by a medical board. The board determines whether or not a patient is physically qualified to remain on active duty. Patients diagnosed as having AIDS are considered to be too seriously ill to remain on active duty and are placed on the TDRL. Each AIDS case is then referred to the physical evaluation board. The PEB determines if the patient should be transferred to the permanent disability list and the amount of compensation the patient should receive.

A diagnosis of AIDS does not mean that a person is homosexual. But doctors must ask each patient questions about sexual preference, since male homosexuals are in a high-risk category for contracting the virus. The official Navy policy is that members are considered homosexual only if they admit to homosexual activity.

If a person admits to being homosexual, this is kept in confidence between patient and doctor only if this admission is derived on the basis of a medical evaluation *following* an AIDS diagnosis.

For those people diagnosed as having AIDS, there may be a difference in the type and condition of separation from the service they receive. Patients who have not admitted, *before* any clinical evaluation, to homosexual activity, will most likely receive a medical retirement. Medical retirements do not have any conditions attached; there is no "honorable" or "other than honorable" designation.

However, if the person is discovered to be a homosexual prior to any screening or clinical evaluation, and is later found to have AIDS, that person may be

administratively discharged, with the discharge type being determined by an evaluation of the individual's service record.

Thus, the Navy's policy is quite clear: AIDS is a medical problem and will not be used as a way to target personnel for disciplinary action.

The goal of the Navy's AIDS policy is to make the patient as comfortable as possible while he or she is in the Navy. But, because of the severity of the illness, personnel with AIDS are being discharged as not fit for duty.

People throughout the Navy, and throughout society in general, are being more and more widely affected, directly or indirectly, by the spread of AIDS.

According to the U.S. Surgeon General, C. Everett Koop, "AIDS no longer is the concern of any one segment of society; it is the concern of us all." □

— Story by JO2 Mike McKinley

This information was compiled from the U.S. Public Health Service's "Surgeon General's Report on AIDS" and the Naval Medical Command's "Navy Medicine Fact File." For more information, contact the USPHS Public Affairs Office at: USPHS PAO, Hubert H. Humphrey Building, Room 725-H, 200 Independence Avenue S.W., Washington, D.C. 20201, phone 1-800-342-AIDS; or Commander, Naval Medical Command, Public Affairs Office, 2300 "E" St. N.W., Washington, D.C. 20372-5120, phone (202) 653-1315, Autovon 294-1315.

Mercy's crew makes thousands of new friends during shakedown cruise.

Angels of Mercy

Story by Lt. Cmdr. Deborah Burnette

Photos by PHC Chet King

The Philippine sun gleams off the mammoth white ship, raising the deck temperature so high that a short walk burns through your shoes. Off the port side, a 33-foot utility boat pulls alongside and offloads its precious cargo — Philippine men, women and children arriving for surgery. About four miles away, at an elementary school, thousands of other people stand in long lines, awaiting outpatient treatment. More than 150 U.S. military medical and support personnel work side-by-side with local Philippine doctors and dentists to treat a wide range of diseases and injuries.

The ship is the Navy's newest floating hospital, USNS *Mercy* (T-AH-19), on a shakedown cruise to the Western and Southern Pacific. For five months, the 700 people aboard traveled from port to port in the Philippines and to several small South Pacific islands, delivering medical care to thousands of patients. The mission, which began when *Mercy* left San Diego at the end of February, was for humanitarian purposes as well as the training opportunities. The first hospital ship in the fleet since 1973 (when USS *Sanctuary* (AH 17) was decommissioned), the newly converted ship had to be "shaken down" and its crew familiarized with operating the modern hospital facilities in remote locations.

Mercy is unique for a number of reasons. The hospital ship is a former crude-oil tanker that weighs in at a whopping 69,000 tons. The 894-foot behemoth is larger than some of the older aircraft car-

riers in the fleet. The crew for the Philippines voyage was a rare mixture — 72 civilian contract Merchant Marine officers and seamen to operate the ship, 91 U.S. Air Force medical and support personnel, 85 U.S. Army medical personnel, three Public Health Service nurses, 65 medical people from the Armed Forces of the Philippines and 385 U.S. Navy personnel, including four small-boat crews, a helicopter detachment, a dozen safety divers, nearly a hundred supply personnel (who also took care of cooking and doing laundry for this small floating city), and some of the finest private medical practitioners in the world.

The Philippine portion of the mission took the ship to seven ports and provided medical care to more than 55,000 people. Treatment for acute diseases and





(Far left) A hospital corpsman on USNS *Mercy* examines a Filipino child.
(Left) A Sea Knight helicopter drops a cargo net on the flight deck of *Mercy*.
(Below) *Mercy* underway during shakedown cruise.



Angels of Mercy

minor surgery were provided ashore, usually at a local school or college, and Filipino doctors, dentists, nurses and other volunteers from each location augmented the joint U.S.-Philippine medical teams from the ship. Aboard *Mercy*, five of the 12 operating rooms were always in use at any given time as surgeons performed major operations on 125 to 150 patients in each port. The outpatient clinics treated even more people, but it was usually the surgery patients whom crew members remembered most.

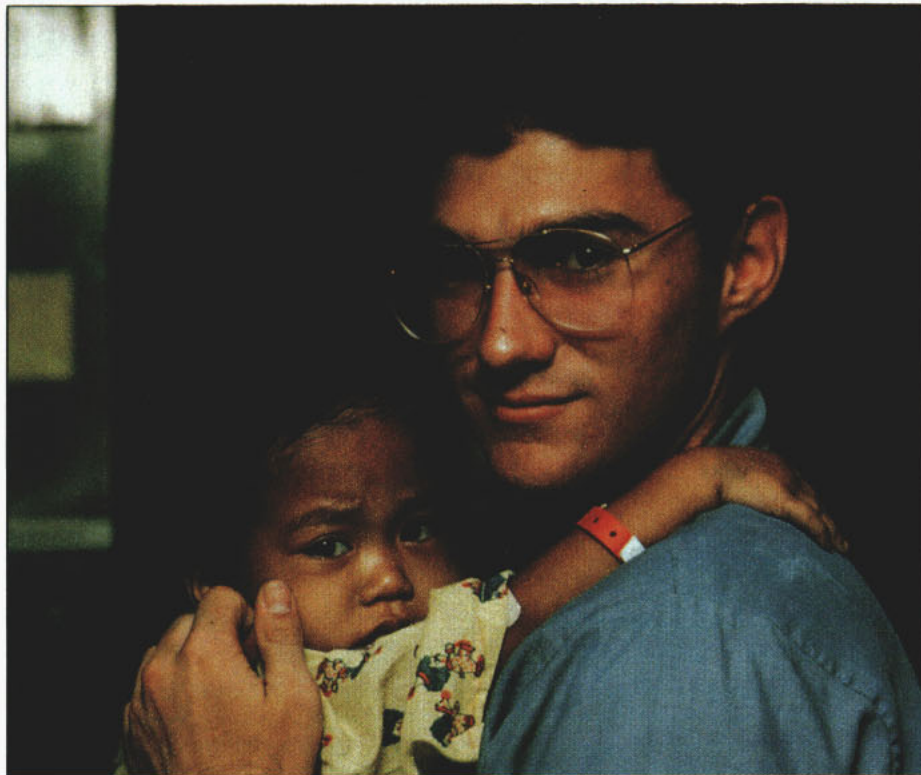
There was Aida Balunso, a 15-year-old girl from the southern Luzon city of Legazpi. Aida lost her left eye when it became infected following an operation for cataracts. She was a shy girl who rarely smiled when she came aboard the ship. But when she left three days later, with her new prosthetic eye, she was all smiles. "You've made me the happiest girl in the world," she told Second Class Dental Technician Eric Eclavea, a Filipino who joined the U.S. Navy and now specializes in oral and facial prosthetics. (See the July 1987 *All Hands*.)

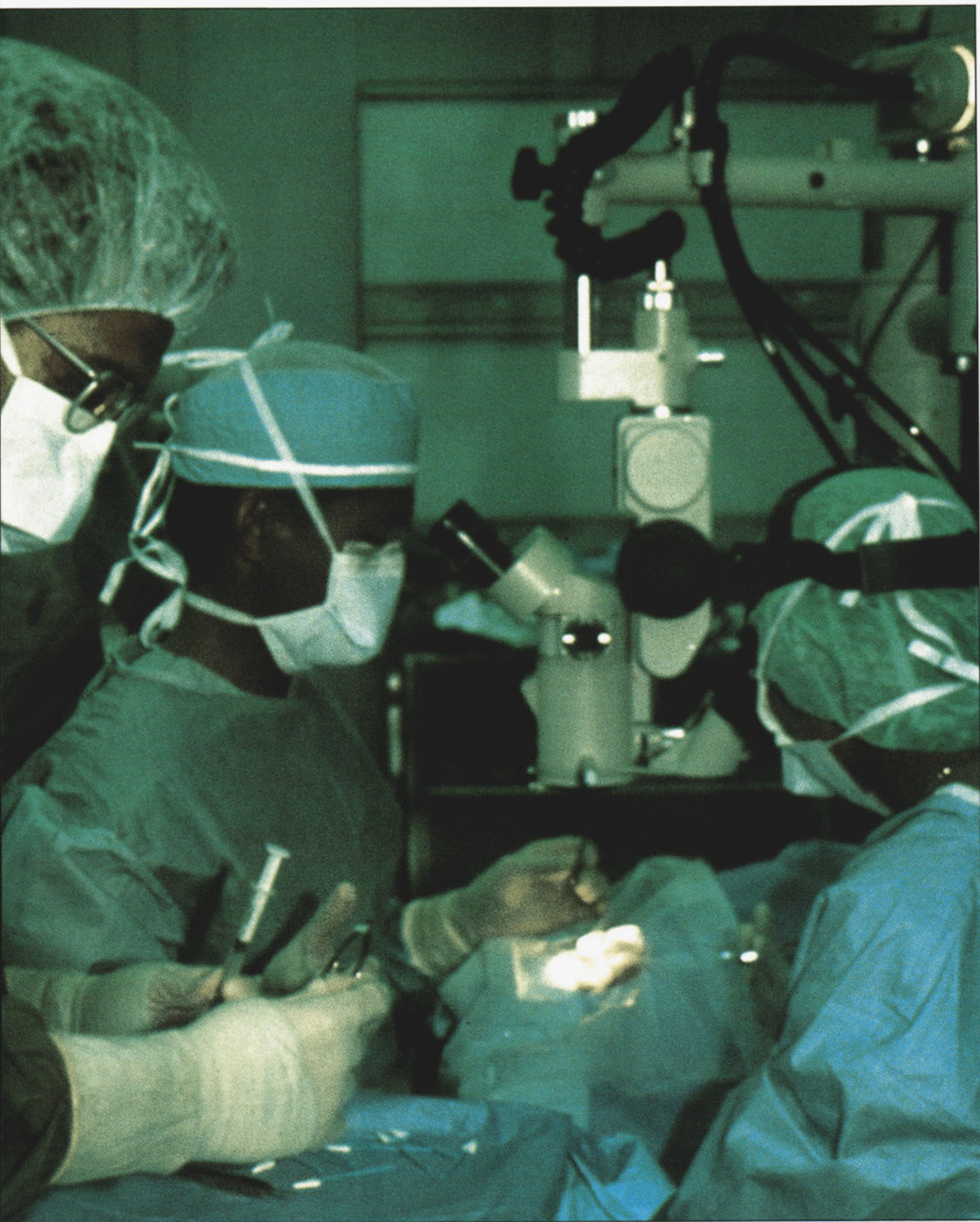
Then there was "Mr. Bing," a

70-year-old man who came aboard unable to see at all because of the cataracts in both eyes. His surgery was a complete success. He wept openly when he was discharged, and hugged his favorite nurse, Army Capt. Elizabeth Stewart, who shed a few tears herself. More than 50 people had their sight restored during the cruise by the ophthalmic surgeons aboard *Mercy*.

Isabel, 40, with six children at home, was so grateful to the surgical staff that successfully removed her enlarged thyroid, she promised to write a song about them and the ship. Maria and Marretta Bonite, 6- and 8-year-old sisters who came aboard for repair of cleft lips, were ecstatic to rejoin their parents at the pier, but 4-year-old Ernie had become so attached to the Air Force technician who worked nights on the pediatric ward, he didn't want to leave. Little Jennifer, 6 months old, was brought aboard in

(Below) A Filipino infant is comforted by a hospital corpsman on board *Mercy*. (Right) A doctor and medical technicians perform surgery in one of *Mercy*'s operating rooms.





Angels of Mercy

Davao suffering from dehydration and severe malnutrition. She rapidly became the darling of the ward during her week-long stay. Several other youngsters, who had been burned by kerosene lanterns as toddlers, are now able to lift their heads, flex their hands and walk upright after having their burn scars repaired.

"It's both a heartening experience and yet a frustrating one," said Navy Capt. Robert Abbe, Director of Surgical Services. "For every patient we're able to operate on, we have to turn 10 or 12 away. Either their illness is one we can't treat surgically, their overall health is too poor for them to benefit from surgery, or our surgery schedule is too full. It's the ones I have to say 'no' to that break my heart."

The idea for *Mercy's* mission to the Pacific came from Adm. James A. Lyons Jr., then Commander in Chief of the Navy's Pacific Fleet. Knowing that the new hospital ship was about to be readied for a shakedown cruise and that medical care was a top priority for Philippine President Corazon Aquino, Lyons pushed the idea in Washington. When Aquino visited the U.S. last fall, President Reagan offered her the services of the ship during its maiden voyage. Two months later, Aquino accepted and the *Mercy* mission was underway.

Capt. Richard Hosey, Master of the

ship, is responsible for its safe and efficient operation. The ship, which has a 34-foot draft, was too large to pull into most Philippine ports and had to anchor between a half-mile and five miles out, depending on the port. A detachment from Helicopter Support Squadron Five in Guam transported supplies and staff from the ship to the shore clinic sites every day, and patients and staff were ferried by small-boat. An ocean-going tug, USNS *Sioux* (T-ATF-171), accompanied *Mercy* on its Philippine port visits to help anchor the ship and ferry heavy medical equipment, such as dental chairs and field sinks, ashore.

Rear Adm. Donald Sturtz, a Navy surgeon, commanded the hospital aboard *Mercy* during the cruise and took great pride in his crew. "We have touched the hearts of so many people here, and have done so much good for so many more, we will carry this experience with us forever," he said.

In many respects, the mission was a difficult one. Most of the crew had never been to sea when *Mercy* left San Diego, and better than two-thirds were seasick during a four-day storm in transit. It took 18 days to cross the Pacific to Subic Bay, and boredom and anxiety were common maladies. Logistics were also difficult to manage. Setting up clinics ashore is no easy chore. In many of the

ports, water was in short supply, and what there was, was not always potable. Power at the shore clinics was 220 volts and usually too limited to support dental chairs, surgical lights, X-ray equipment and other gear. So in addition to two water tanks, *Sioux* also carried portable generators for the clinics.

The tropical climate also took its toll. On some of the hottest days, when temperatures climbed over 100 degrees, medical personnel often had to return to the ship to be given intravenous fluids to counter dehydration.

But ultimately, helping people was easy, even though it involved enormous amounts of work. The most difficult part was seeing all the patients that couldn't be helped. In Davao, the third stop for the ship, more than 30,000 people came to the shore clinic in one day seeking medical care. The clinics, at the very most, could see a maximum of about 1,300 people. Because of the huge crowds, it was impossible to get patients into the school where the clinic was held, so treatment was postponed until late in the day, when the number of people thinned out.

"Everywhere we went, we had more people coming in for help than we could possibly see, and that really took a toll on our staff," said Sturtz. "What kept us going were those that we *were* able to help. I went to the wards every day to see the people who had surgery, just to keep some perspective," he said.

"The mission was a wonderful experience," said Hosey. "It illustrates the best part of our national character — reaching out to help people who need it desperately. Seeing a person who had serious medical problems, and no hope of solving them, walk off the ship with a changed life made all the long days worthwhile." □

Burnette is the Director, NavInfo, Atlanta. King is assigned to 7th Fleet PAO.

***Mercy's* crew brings aboard a patient for a surgical operation during its five-month cruise throughout the Philippines and other South Pacific islands.**



Photo by Sp4 M. Hagburg

Mercy on call

Story by Tech. Sgt. Cordelia L. Rackley

USNS *Mercy* (T-AH-19), the U.S. Navy's newest hospital ship, is designed to support Rapid Deployment Forces in the Pacific theater. RDF support would

almost certainly require extensive emergency medical care.

Mercy's emergency response training was put to the test during a scheduled

port visit to Zamboanga City, Republic of the Philippines. A truck overturned on Basilan Island, killing 14 people and injuring 57. Those most seriously injured were airlifted to Zamboanga City, where local officials requested assistance from *Mercy*, anchored about a mile offshore.

Two doctors, along with medical supplies, were sent ashore to assess the injuries. Six of the injured were transported by boat crews to the ship's medical treatment facility. Medical teams from the U.S. Navy, Army and Air Force, the U.S. Public Health Service, and the Philippine Armed Forces immediately began treatment. It was the first time that patients were brought aboard *Mercy* for emergency medical treatment.

"What we're seeing here is our Navy training really put to use," said Hospital Corpsman 3rd Class Stacia Harriman, an orthopedic specialist.

"This is what the ship is about — what it's designed to do," Harriman said. "This is a true humanitarian mission, where we can use our training to help out in time of need."

During the emergency, three men, two children and a pregnant woman were rushed on board into the casualty reception area. Their injuries included fractured arms and legs, burns and severe lacerations. Four of the six underwent emergency surgery that lasted until the early morning hours.

Navy Capt. John Matheson, a dental surgeon, performed a four-hour rigid fixation and fracture repair surgery on

Medical crew of *Mercy* aids the victim of an auto accident in the port city Zamboanga, Mindanao, Republic of the Philippines.

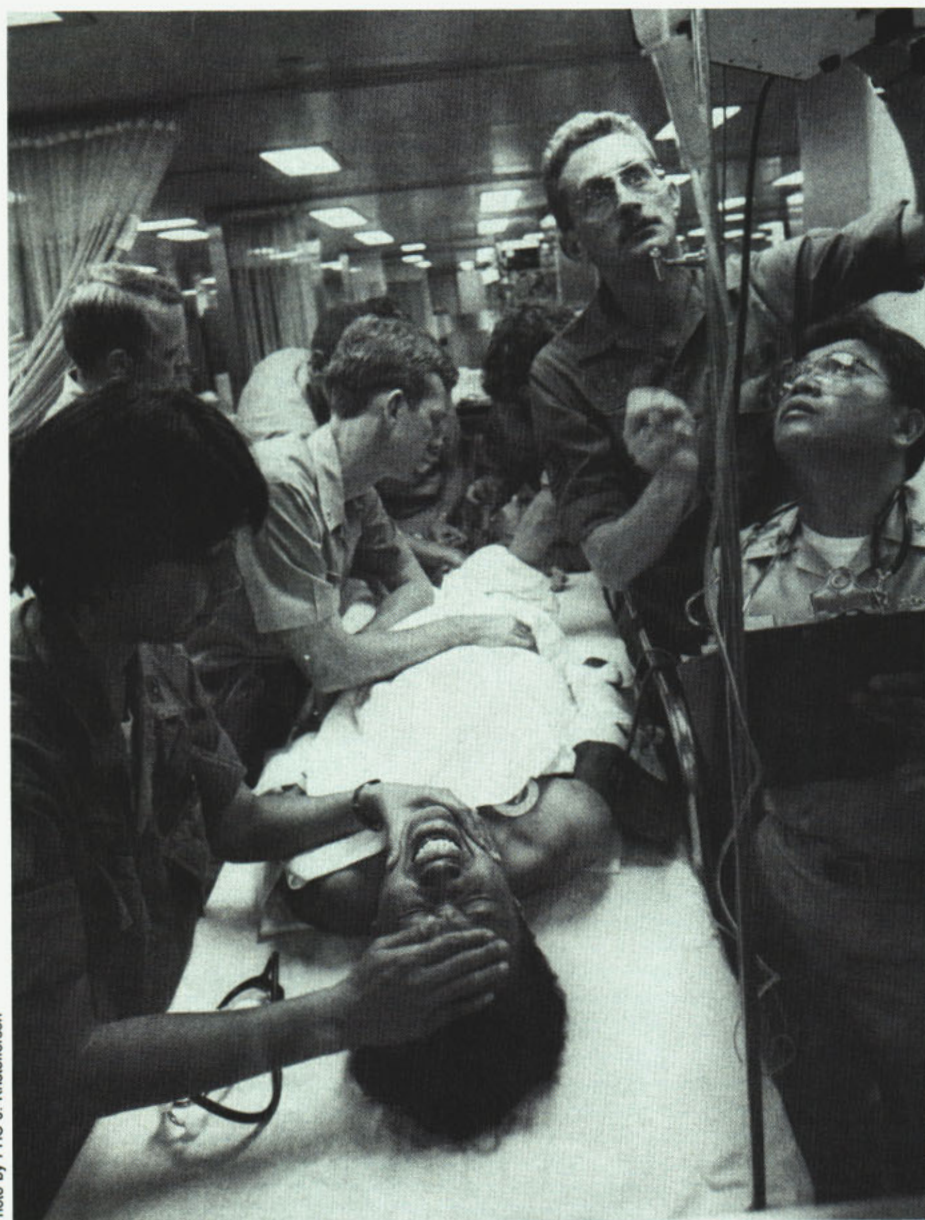


Photo by PHC J. Kristofferson

Mercy on call

one patient's jaw. He later said he was impressed with the way trauma training was put to work with such speed and efficiency.

"We mustered an entire trauma team, and had four operating rooms on-line and ready to go. We used state-of-the-art surgical procedures and gave these patients the best medical care possible. It was an effective display of training," Matheson said, "and we still maintained a full O.R. schedule the following day."

In the end, all six patients were in stable condition prior to being released to a local hospital for follow-up care, while medical supplies and instruments were supplied to area hospitals in order to assist the treatment of the other 51 accident victims.

"We can be very thankful this ship was here," said Capt. Erlina Nombreda, an Armed Forces of the Philippines nurse who was training aboard *Mercy*. "We didn't have the kind of facilities to accommodate these patients in the local area. It was just a good thing we were there when we were."

"Everyone wanted to be a part of this humanitarian effort — this is what makes the mission all worthwhile," commented Senior Airman Steven Dunnick, an Air Force recovery room technician from March Air Force Base, San Bernardino, Calif.

The tri-service training on *Mercy* paid off, according to the medical treatment facility's commanding officer during the cruise, Rear Adm. D.L. Sturtz.

"I'm glad we were able to help in this case," he said. "I'm very proud of all of the crew who were able to react quickly to evaluate, stabilize and provide definitive care to the patients. □

— Rackley was attached to the PAO office aboard the USNS *Mercy*.

Clockwise from right: Accident victim is treated for facial injuries. A 3-year-old boy's burned hands are bandaged, and his facial burns are cooled with cold cream. Doctors check X-rays of the boy's injuries prior to night-long surgery.





Photo by PH2 Donna Walker



Photo by PHC J. Kristofferson



Photo by PHC J. Kristofferson

A day in the life of a brain surgeon

Zero-dark-thirty. Dr. LaVerne Lovell arrives at Bethesda Naval Hospital. A neurosurgeon in residency begins another day.

By 5:40 a.m. he's on the ward, donning a white lab coat over his Lt. Cmdr.'s uniform. His official identification card hangs from one pocket, adorned with a "Go Navy" sticker.

LaVerne Lovell is 37 years old, and with 18 years of active duty naval service behind him, he has six years of residency ahead of him, plus another seven of obligated service in the Navy after that.

"I like neurosurgery because it is fascinating. It's a subspecialty that taxes your academics, your physical stamina, your operating ability and the best use of your time," Lovell said.

The doctor starts his initial rounds of the ward. He goes to each door, checking for new names, patients who arrived during the night. "It's my own system," he explains.

Lovell set out, as an enlisted man, in 1969 to become an electronics technician, but before finishing ET training, he was accepted to the Naval Academy Prep School in Bainbridge, Md. From there he received a Secretary of the Navy appointment to the Naval Academy and graduated in 1975 with a bachelor of science degree in aerospace engineering. His plan was to become a jet pilot.

It's a few minutes past 6 a.m. and Lovell meets with another resident neurosurgeon in a tiny office/lounge. Lt. John Collins has been on duty for 24

hours. He fixes a bowl of cold cereal and tells Lovell what happened last night.

"I was wrapping up. All's quiet," Collins says. "It was about midnight — and you remember that guy in North Carolina?"

"Yeah," says Lovell, "the pituitary patient."

"Right. I'd told him to come in any time. . . ."

"So he shows up at midnight, right?" replies Lovell, grinning. Collins nods, grimacing, and finishes his breakfast.

"Early in my fourth year at the Naval Academy the rush was on by Adm. Rickover's group to convince people to come into the nuclear power pipeline," said Lovell. "It was one of those tough decisions — I liked Navy air, but submarines looked so exciting to me. . . ."

Lovell faced a lot of life-changing choices. He elected to interview with Rickover and was selected for the nuclear program. At the same time, he and his fiancée, Peggy Weik, made the decision to marry. So after his June '75 graduation from the academy, he entered the year-long nuclear power training and married Peg on July 4th weekend that same summer, a series of events inextricably bound together in his memory.

By 6:10, the chief resident, Lt. Cmdr. Ron Hargraves, arrives. He makes the morning rounds with Lovell and Collins, talking with each patient. In the "step-down unit," a sort of halfway point between intensive care and the regular ward, they gather around Martin. His

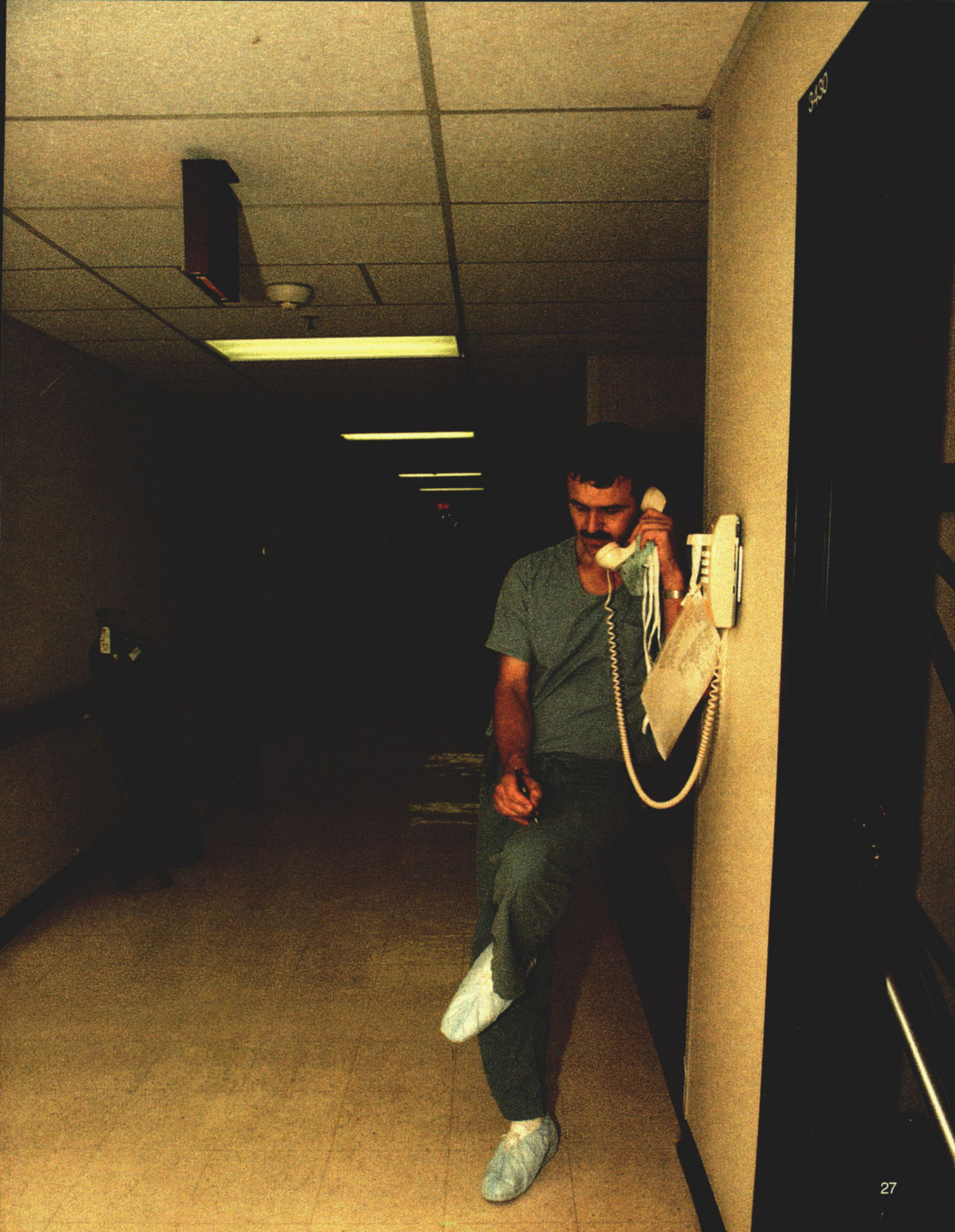
head is swathed in bandages. "Martin! Wake up, Martin!" Hargraves tries to arouse the young man. Martin answers sleepily. He is a second class petty officer with a preliminary diagnosis of a brain tumor. He underwent surgery the previous day. He is responding to treatment, but his condition remains serious. Lovell takes notes as Hargraves orders tests.

After completing nuclear power training, Lovell reported to USS Sargo (SSN 583) homeported in Pearl Harbor, Hawaii. Later he would serve aboard the construction crew for USS Dallas (SSN 700) and then teach at the Naval Submarine School in Groton, Conn.

Lovell and the others move from room to room. It's 6:45 a.m., the halls are still dark and it's quiet. They enter Charlie's room. He has the covers pulled over his head, but Hargraves rousts him out and talks to him briefly. Charlie is afflicted with a progressive spinal disease that might be staved off, but not cured. He was an all-America basketball player in high school.

After five years in the submarine community, Lovell was at a crossroads in life. "I remember that evening very well," he said. "I came home distraught over what the future held. I told Peggy, 'I can't decide. There are so many different options!' I threw my hands up in the air and said, 'I don't know what to do.' Peggy said to me, 'What do you

A neurosurgeon in residency jots down his many phone messages when and where he can.



Brain surgeon

really want to do?' It was literally like this" — Lovell reaches behind his head and flips on a light switch — "I said, 'I always wanted to go to medical school.' I think her shoulders might have drooped a bit, but she really didn't bat an eye."

Peggy is sitting across the table. "Nothing surprised me at this point!" she exclaimed with a laugh.

"Her comment to me was a simple, 'Let's go ahead and do it.' We literally started planning from that night," Lovell said.

He began taking night classes in subjects like biology and anatomy, and in the summer of '81 applied to 13 medical schools.

The team reaches the room of Jack from North Carolina, Collins' patient with a pituitary tumor. He explains that Jack is a retired Navy E-6, 72 years old, and outlines his medical history. They all chuckle at hearing the story of his mid-night arrival. They know how it is on night duty.

Asked to interview at four medical schools, Lovell chose to attend the Uniformed Services University of the Health Sciences, located on the grounds of Bethesda Naval Hospital. He began school in July 1982.

"I've always been in search of what I wanted to do," Lovell said thoughtfully. "I don't think Peg and I have ever felt that anything — other than our marriage — has to be forever. That's how I've always felt about my Navy career. I've always looked to move up in life. I don't mean financially, but to enjoy more of life. . . . To move from submarines to medicine was more of what I wanted to do."

The rounds are over. It's 7:15 and Lovell gathers with six other doctors — all neurosurgeons on staff or in residency — in a small room to look at "films," pictures taken by CAT scanners, different views of brains and spinal columns. A lively discussion ensues about proper treatment. Collins is questioned closely by the staff neurosurgeons regarding Jack's case. The staff is concerned. The pituitary tumor may or may

not be the cause of Jack's complaint.

Now that he has made it to this point in his career, Lovell is enthusiastic about his new experiences. "I think the discussions are excellent," said Lovell. "That's the process by which you arrive at the best possible treatment for the patient. You get a lot of different minds on one problem. That's the academic environment we have at the hospital."

Lovell, as a neurosurgeon in residency, is still under instruction. He joins the other residents at training lectures and meets with other neuro-specialists at Walter Reed Army Hospital for discussions of cases. This is in addition to his average 15-hour workdays and 24-hour duty every third day.

By 7:40 a.m. the meeting in the film room is over. There's actually time for breakfast today, albeit a quick one. "You learn to do things when you can — eat when you can, sleep when you can," he says. "You think you've got lots of time, the whole day before you. Then your beeper goes off five times in five minutes and you have six things to do at once." Lovell carries a beeper with him around the hospital so he can be located easily. Each resident carries one.

"It might sound corny, but early in my residency I realized that after I've completed a long period of duty in the hospital I leave with almost a refreshed feeling. Something I have done that day has improved the quality of someone's life. You know the Seabees' motto, 'Can do'? I really like that. You realize your full potential when you work hard at a job. And that is when you really are proud of what you've done," he said.

After chow, Lovell goes by the film room to pick up a couple of views of a patient's spine. He wants to discuss her case with her and answer any questions before she's released today. He goes up to the ward to see her in her room. Next, Lovell heads down to the operating rooms, "O-R," to see how the day's first surgery is being set up. He changes out of uniform and into clean, green "scrubs." The outfit includes paper covers for his shoes, a green hairnet and

a face mask. Every time he leaves O-R, the face mask and hairnet are discarded. Everytime he returns to O-R a fresh mask, hairnet and shoe covers are put on. The lab coat is likewise taken off for O-R, and put on when he leaves it. Lovell comes and goes from O-R all day.

It's 8:58. The beeper goes off. Martin, in the step-down unit, is becoming harder to arouse. Lovell heads back to the ward.

When he took on the neurosurgery program, Lovell was questioned by some about his commitment to his family. "People actually made comments about how we. . .," he hesitated.

"They actually insinuated," interrupted Peggy, "that this would suit us for him to be gone as much as he is, or perhaps LaVerne's not the family man he should be."

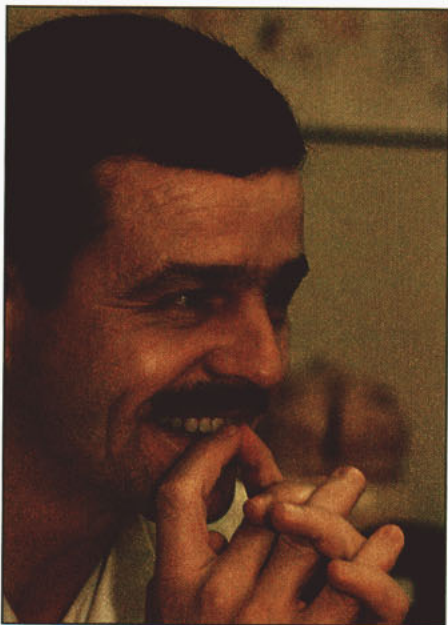
"I took offense at that," Lovell said, "because I know people who spend a lot less time at their work and a lot less time with their kids."

However, he recognizes that his time with his wife and children is far too short. "The worst part of this residency is the sacrifice you make with your wife and kids," he said. "I would be lying if I said I spend all the time I needed to with them. I try to set aside as much time as I can when I'm home to do things with the children — even if I'm tired — games, like going outside to play kickball, getting their baths, saying their prayers."

Lovell has a daughter, Kelly, age 11, and two sons, 8-year-old Hunter and 5-year-old Conrad.

Martin isn't looking good. Lovell decides to take him for an immediate CAT scan. He works with nurses and hospital corpsmen to get Martin moved to a gurney, transported to another department and onto the scanner bench.

(Clockwise from left) Dr. LaVerne Lovell in a relaxed moment. Lovell talks with a patient in her hospital room before her release. Comparing a patient's CAT scans, performed on different days, is an important diagnostic tool.



Brain surgeon

(Left to right) Lovell prepares a patient for surgery. He spends a minimum of ten minutes scrubbing up before an operation. During surgery, Lovell has a wide range of instruments ready for use. Outside of surgery, it's paperwork-paperwork-paperwork, and no time to look for a chair.



Lovell talks to Martin — “How’re you feeling? Still with me Martin? Open your eyes for me.” Martin is in pain, and whimpers every so often.

By 9:25 the scanning is underway. Lovell stays close to the computer screen to see the results. The scanner technician asks if Martin is going to make it. “In the long run?” Lovell asks. She nods. “Probably not,” he replies.

“A lot of times you initially treat a patient not knowing the true cause or full extent of their disease,” Lovell said. “You start to treat patients and may even operate on them with the hope in your mind or heart that you can cure them. But you find out later they have a disease that will be terminal.

“Sometimes you know this when you start, and you still elect to operate or treat in an attempt to improve the length and the quality of their life,” he continued. “When that happens you relegate yourself to the role of helper as opposed to curer.”

At 10:24, after an extended period in the scan area and responses to numerous beeper calls, Lovell is back on the ward.

He explained that the doctor’s goal is not necessarily to extend a patient’s life as long as possible. “What we try to do is include the family in the decision-making process. We have an excellent chaplain corps, social workers and a physical therapy department. That team of professionals assists us by helping the family and patient get the maximum possible benefits out of what treatment we can give them,” Lovell said.

Treatment is always optional, and some patients and their families choose against treatment. “The majority of people are prone to grasp at any thread that might offer some additional help. I think it takes a very wise, thoughtful person who can make a decision that may not offer them the longest life span, but will not prolong their misery,” he said.

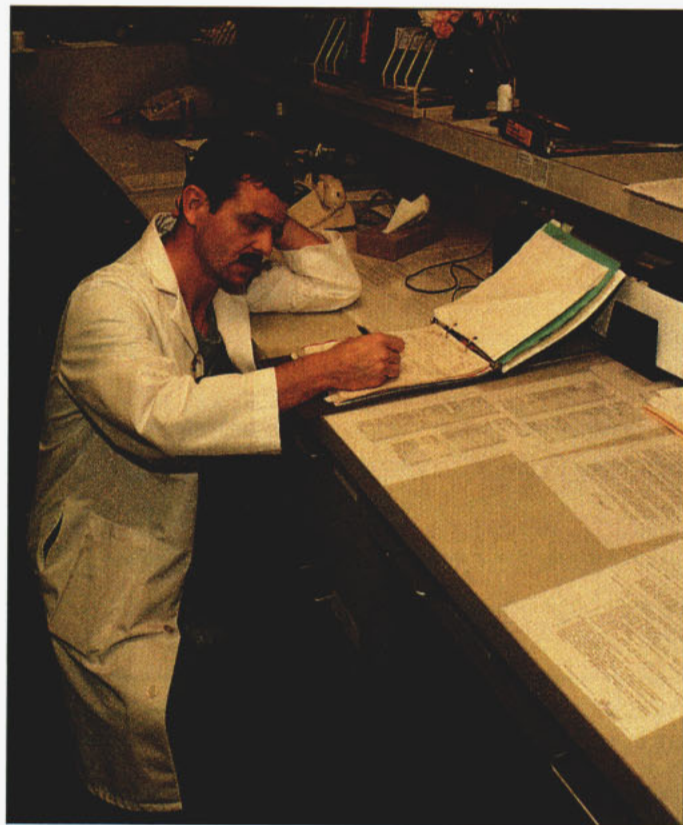
Lovell is back in O-R shortly after 11:00 a.m., checking on the progress of the day’s first operation. A team of doctors and assistants, nurses and corpsmen, surround the patient, and are in turn surrounded by equipment. Bill, the patient, is undergoing removal of a diseased pituitary gland. The doctor operates looking

through a microscope. Progress is slow and Lovell discusses the surgery schedule with other doctors. One of today’s operations will have to be delayed.

Another beeper call — Jack, the elderly man who was admitted the night before, has passed out. Lovell heads out of O-R to see him but several more beeper calls stall him on the telephone in the O-R area. At 12:18 p.m., he sees Jack on the ward. He’s in bed, two family members on hand. Lovell begins by asking him what happened, then checks his thought processes. Simple tests suffice. “Count backward by threes from 100,” requests Lovell, and Jack does. Lovell interrupts, asking, “Who’s the president?” “Oh, that fellow!” answers Jack. Everyone laughs. “I think we have a democrat here,” Lovell says, laughing with the others.

“I think my religious upbringing makes me realize the human side of medicine, that each individual person is a person of God,” said Lovell.

“It allows me to treat them as human beings and realize that not all problems in medicine are for us to fix necessarily.”



In the case of a brain tumor, operating may help but can't always solve the problem. However, neurosurgery also deals with the spine and other areas of the body. If an individual has chronic back pain, a neurosurgeon is often able to alleviate the trouble and return the patient to a normal, active life.

Lovell finds excitement in meeting such challenges. "Neurologic sciences are fascinating because we *don't* know the answers to so many things," he said.

The afternoon sees Lovell running between the ward and O-R, consulting with nurses about medication, completing paperwork, talking on the phone. He moves fast, often opting to take the stairs instead of the elevator from floor to floor. He skips lunch.

In spite of the demands on him as a neurosurgeon in residency, Lovell considers his family to be what's most important in his life.

"We have a family joke," explained Peggy. "We call LaVerne 'Handy Smurf' because he always has toys or something to fix at home." She smiled as she described a scene: "Handy Smurf

comes home from doing brain surgery to fix robots and the lawnmower." Both Lovell and Peggy burst into laughter.

"When I come home and the kids are lined up for kisses and hugs, each one has something in their hands that broke that day, which they want me to fix," Lovell said. "It's become humorous in our house, and I think that's part of what keeps me from getting angry about it. I come home and I feel needed."

The remainder of Lovell's day is more of the same. He performs minor surgery for a biopsy, answers endless beeper calls, makes the afternoon rounds, and then spends the night on duty. At midnight, two new patients are admitted via the air-evacuation system which brings people in from overseas or other areas of the states. There are a couple of emergency room calls. He's up all night.

"LaVerne is a content man," said Peggy, "but he's never completely satisfied. I think that's what drives him."

It's that drive that enables him to endure the grueling schedule of a neurosurgeon in residency. It's the patients, however, that keep him interested; Lovell

enjoys working with people.

Lovell's routine is the same every day: week in, week out. He follows with interest the progress of patients on the ward. A week later, Jack has unexpectedly lapsed into a coma. Tests show he's suffered a stroke which is unrelated to the pituitary tumor. Martin, however, is doing better now, sitting up in a wheelchair. He will soon head for home. Charlie, the basketball player with the progressive spinal disease, has been released, but will probably be back.

"That sort of case bothers me," said Lovell. "There's nothing we can offer Charlie right now that will ensure success. How do you deal with them? You eventually recognize that you're not made to cure all diseases."

But Lovell isn't one to give up, even when the odds are against him. "There's a phrase my Dad used to tell me," Lovell said, "Can't never did nothing." That's part of my attitude." □

— Story by JOC Robin Barnette.
— Photos by PHI Chuck Mussi.

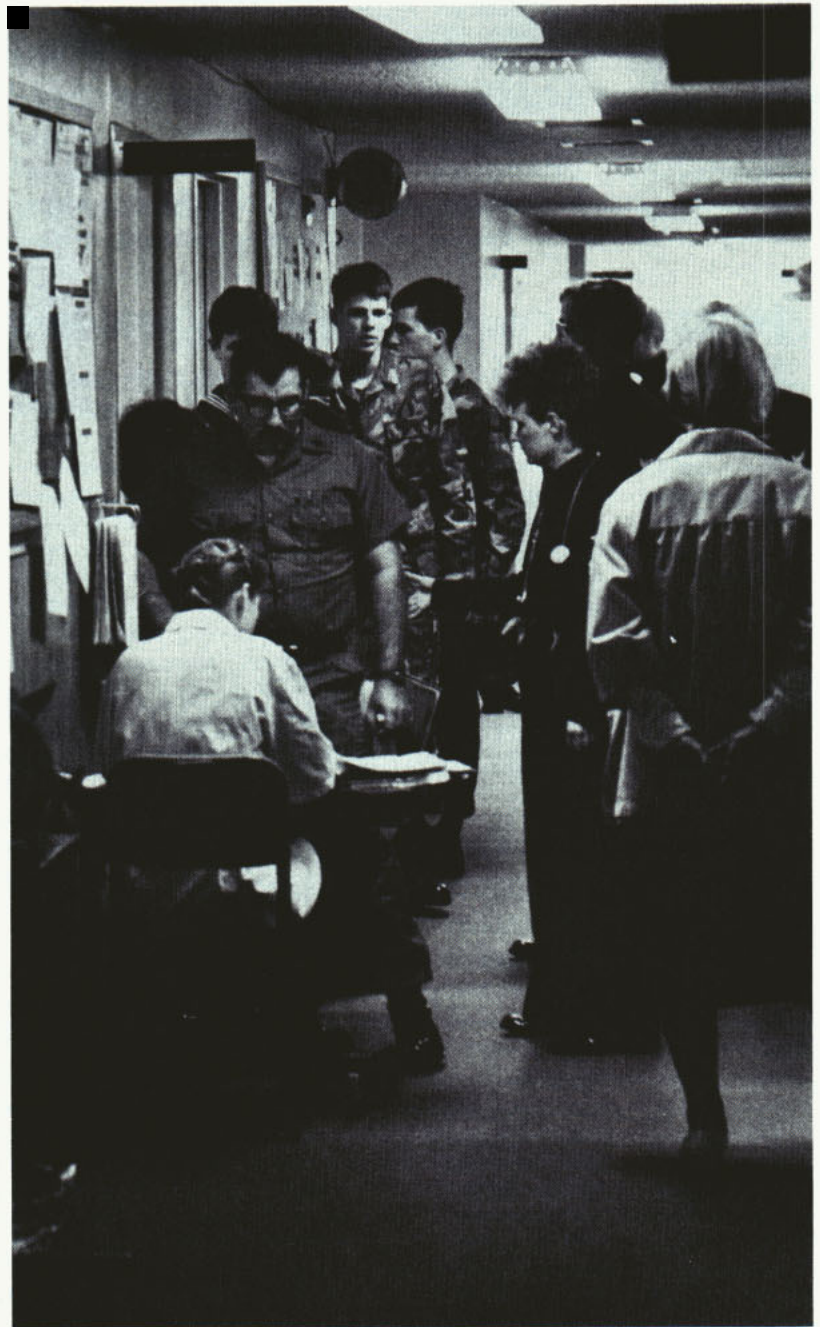
Family practitioner

Story and photos by Dave Fraker

Variety and constant challenge fill up the long days.



Lt. Dennis Rowe empathizes with his patients, developing a relationship of care and understanding.



Dr. Dennis Rowe lives in a world of constant challenge. When he steps behind the curtain, he is not sure what he might find.

"That's the excitement of family practice," said the 38-year-old Navy lieutenant. "We see real variety and all age groups, from the unborn to the geriatric."

Rowe works at Naval Hospital Lemoore, Calif. He is one of five physicians, who, along with five physician's assistants and one nurse practitioner, all work in the hospital's family practice department.

Rowe is a transplanted New Englander from Portland, Maine. He entered the Navy directly from high school as a corpsman. He was 17.

"I served six years on active duty, then put my GI Bill to use and went to pharmacy school," he said. He completed the five-year school in four years and continued to serve in the Naval Reserve as a chief corpsman.

To support himself and his growing family, Rowe worked at two part-time jobs while he continued his Navy career by drilling as a Ready Reservist. His wife contributed through her job as a Tupperware dealer. "I remember coming home many nights and finding the house littered from top to bottom with Tupperware when my wife was packaging orders," he said.

Eventually, it all paid off and Rowe found his way to the Uniformed Services University of Health Sciences, where he earned his medical degree.

"The Navy slots for the school were filled the year I applied, so I had to sign on as an Army lieutenant for the first two years," Rowe recalled. "During the summer, I slept in the mud and jumped out of helicopters."

He served one tour at the Naval Hospital in Pensacola, Fla., where he was trained in family practice. When he transferred to Lemoore (and the Navy), Rowe was chief resident.

As he progressed from corpsman to chief resident, Rowe learned a lot about handling family practice cases.



"I try to empathize with a patient, to understand how they feel," Rowe said. "I sit back and listen and let them tell me what *they* think is wrong. I also take time with my patients and try to develop a relationship of care and understanding.

"I think a lot of visits could be handled at home if people had more of the right information," he continued. "And I think one of our biggest problems as doctors is that we sometimes don't listen to our patients very well."

On the job, Rowe gets plenty of opportunities to listen to his patients.

A typical day for Rowe begins at 7 a.m. with rounds at the hospital. He may have from two to five in-patients and he makes his rounds with his physician's assistant, Don Erwin. Together they read

charts, talk with patients and discuss progress. Every PA at the hospital is assigned to a doctor.

Then military sick call begins at 8 a.m. Rowe may see a person who complains of constant headaches or a patient with a sore foot caused by a horse stepping on it.

Through all this, Rowe also sees regularly scheduled patients. There are allergy problems and prenatal or postnatal checkups. He might perform a well-baby checkup or write a prescription to refill a stroke patient's medicine.

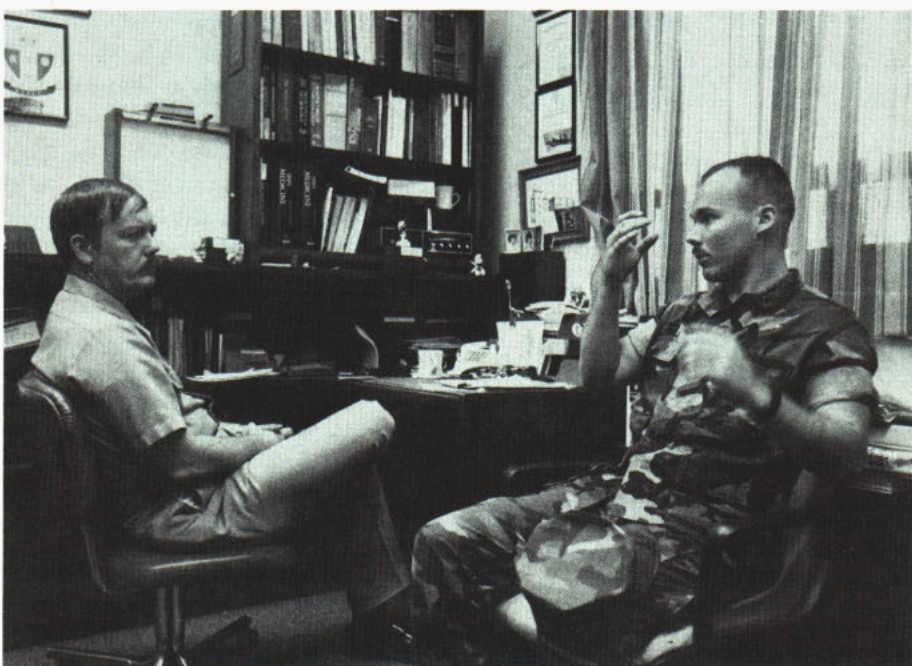
Rowe also joins other staff medical personnel who meet monthly to discuss problems or unusual cases, as well as methods of streamlining certain hospital procedures.

On Thursday, Rowe assists the chief of surgery during scheduled operations.

"As you can see," Rowe said, "I get to do a bit of everything in family practice. The medical experience is invaluable and I'm serving my country at the same time."

Sure beats living on Tupperware sales and sleeping in the mud. □

Fraker is editor of The Golden Eagle at NAS Lemoore, Calif.



Thanks:

HMCN Roger W. Yack of Cruiser-Destroyer Group EIGHT wrote All Hands about treatment he received in a Navy medical facility — treatment that he believes saved his life.

“The one person I dreaded seeing was the respiratory technician, (the suction monster).”

I am a master chief petty officer with 24 years of Naval service. I am 43, in good shape, physically active and have always been generally in good health. However, on the negative side, I am a bit overweight, although within Navy standards, and smoke entirely too many cigarettes.

In June 1985, I began experiencing a mild discomfort in my lower back, which I ignored, feeling sure it would subside. The discomfort persisted for a couple of days and I felt I may have strained my back, though I could not recall any heavy lifting or stress.

Eventually I told my wife about the pain. As I laid on my back, I had her press on my abdomen. I found that pressure on the left upper area of the abdomen caused tenderness and a sharp pain from there to my mid-lower chest area. I was somewhat concerned about this, but reasoned it was either a urinary tract infection or from my one and a half-pack-a-day cigarette habit. My wife was more worried than I was and made me promise to “do something” about it the next day.

The following morning I went to work as usual. I worked at the Naval Hospital in Portsmouth, Va., so I knew some of the staff there. I decided to have a friend in the laboratory run a urine test to support my guess of a urinary infection, then it would simply be a matter of getting a doctor to prescribe the appropriate medication.

The urinalysis was done that day, but the lab technician discovered an inordi-

nate amount of red blood cells in the sample and recommended I seek medical advice. We went to see a pediatric nephrologist. After reviewing my medical history and the results of the urine test, he suggested I might have an early kidney stone which could be treated with a urinary cleansing agent. Before I was to take any of the medicine, he requested I obtain a sterile urine specimen for further evaluation.

When the lab technician studied my second specimen he said “this looks worse than the first one” and felt that the doctor should be notified of the increased severity of the problem. I took the results with me and told him I would call the doctor from my office.

I told my inquisitive staff that I had a minor problem which could be controlled with medication. When I talked with my doctor, he was concerned about the changes in the urine test and suggested I be seen in the urology clinic. A few moments later the phone rang; the clinic was requesting that I report right away.

I presented myself to the young hospitalman at the clinic and within a few minutes I was ushered into the urologist’s office. He began explaining the need to document a history and physical for my file in case I had to return to the emergency room later that evening for further evaluation of the kidney stone.

After taking the history, he felt my abdomen several times, tapped my feet, felt my back and then returned to probe the abdomen. He left the room for a moment and returned with the head of the urology services, who also felt my abdomen and back. The two doctors exchanged words by the door. My urologist

Sailor credits medical with saving his life

told me I could get up and they would arrange for some X-rays, either an IVP (intravenous pyelogram), a KUB (X-rays of kidney, ureter, bladder) or an ultrasound.

Just as we were getting ready to leave the room, he stopped me and said: "Master Chief, in a stringbean-type person it is not uncommon to palpate (feel) an occasional aorta, but with someone who has a little thicker abdomen like yourself it is uncommon to do this. We suspect you may have an aortic aneurism!" I looked at him for a second and replied, "you've really got my attention."

Eventually it was decided a KUB would be done first and we would proceed based on those results.

They shot and developed the film and I was escorted to another room. Things were starting to happen very rapidly and I was becoming very confused. There were seven or eight doctors reviewing my X-rays and I overheard bits and pieces of conversation about surgeons and surgery, IVs and transportation.

I heard someone mention that Norfolk General (a large teaching hospital across the Elizabeth River) had the surgical staff, operating room and intensive care facilities to accommodate the necessary procedure. They also discussed using the regular ambulance, or Nightingale, the emergency helicopter ambulance.

I was started on an IV while the doctor discussed the X-rays, arranged transportation and coordinated the referral procedure to Norfolk General. I was put on a gurney and the adventure began.

I vaguely heard the siren and felt the movements of the ambulance. The traffic must have been held up at the tunnel

because we breezed right through there in the middle of rush hour. It seemed only to take a few minutes to get to Norfolk General.

On arrival, I was first greeted by a civilian doctor who explained that he had already talked with the Navy doctors and now he would do a special X-ray called a CAT-SCAN to get a better look at the aneurism. In the interim, the hospital staff started another IV in my arm while the doctor started yet another in a vein in my neck.

The CAT-SCAN machine resembles an iron lung that feeds your body through while taking continuous pictures. I was still in the scanner when my civilian doctor came to me and said, "the aneurism is larger than we originally thought; we don't want to waste a lot of time, and you need to be in surgery now." My reply: "Let's do it."

After getting the necessary informed consent speech which consisted of him informing me of all the possible complications of the surgery, including the possibility of impotence, paralysis from the waist down or death. I wasted no time signing the consent form.

As we arrived at the operating room, I said to the doctor that I expected, at a minimum, to feel drowsy by now. He replied, "Mr. Yack, please believe me when I say that by the time I am finished . . ." That was the last I remember for two days.

In surgery they opened my abdomen from chest to pelvic area and repaired the aneurism. I was taken directly to the Vascular Intensive Care Unit. I had machines breathe for me, monitor my heart, my blood pressure, venous pressure, IVs, a tube to drain my stomach and another to drain my bladder. The

nursing staff responded immediately to my every request.

Though the entire staff was exceptional in their professionalism, there was one person I dreaded to see, the respiratory technician, (the suction monster). His job was to keep my lungs clear by making me cough and deep breathe. Sneezing, coughing and deep breathing were the three most difficult things I had to do, but the respiratory technician had no mercy: he forced the issue and maintained my lungs very clear of any obstruction. I believe it was due mostly to his efforts that I was discharged from the hospital earlier than expected.

I progressed from intensive care to a regular post-op floor and received good care throughout my stay. I was discharged after only six days in the hospital.

The most important aspect of this experience, to me, was the level of excellence of the staffs involved. In spite of my trying to "buck the system" by not seeing a doctor initially, I must commend:

- The laboratory staff for identifying the abnormality

- The rapid response and referral to a specialist

- The staffs' ability to recognize the presence of the aneurism

- The fact that I was never left alone or out of sight once the diagnosis was made

- The coordination and cooperation between military and civilian hospitals and staff

- The surgical and post-operative care

- The high level of professionalism and compassion of the staff of both the Portsmouth Naval Hospital and Norfolk General Hospital. □

From ghetto to pharmacy

HM3 Rivera forges ahead

Story by JO3 James S. Seda, photos by PHAN Steven D. Smith

The formica countertop is cluttered with an array of electronic monitors, centrifuges and test tubes. It's a high-tech environment, but a very familiar world to Petty Officer 3rd Class Heriberto Rivera, a hospital corpsman aboard USS *Saratoga* (CV 60). Yet it is a world far from his beginnings.

"I grew up on the west side of 51st Street in New York," Rivera said. "A ghetto suburb. There were shootouts, burglaries and muggings. But it made me a survivor.

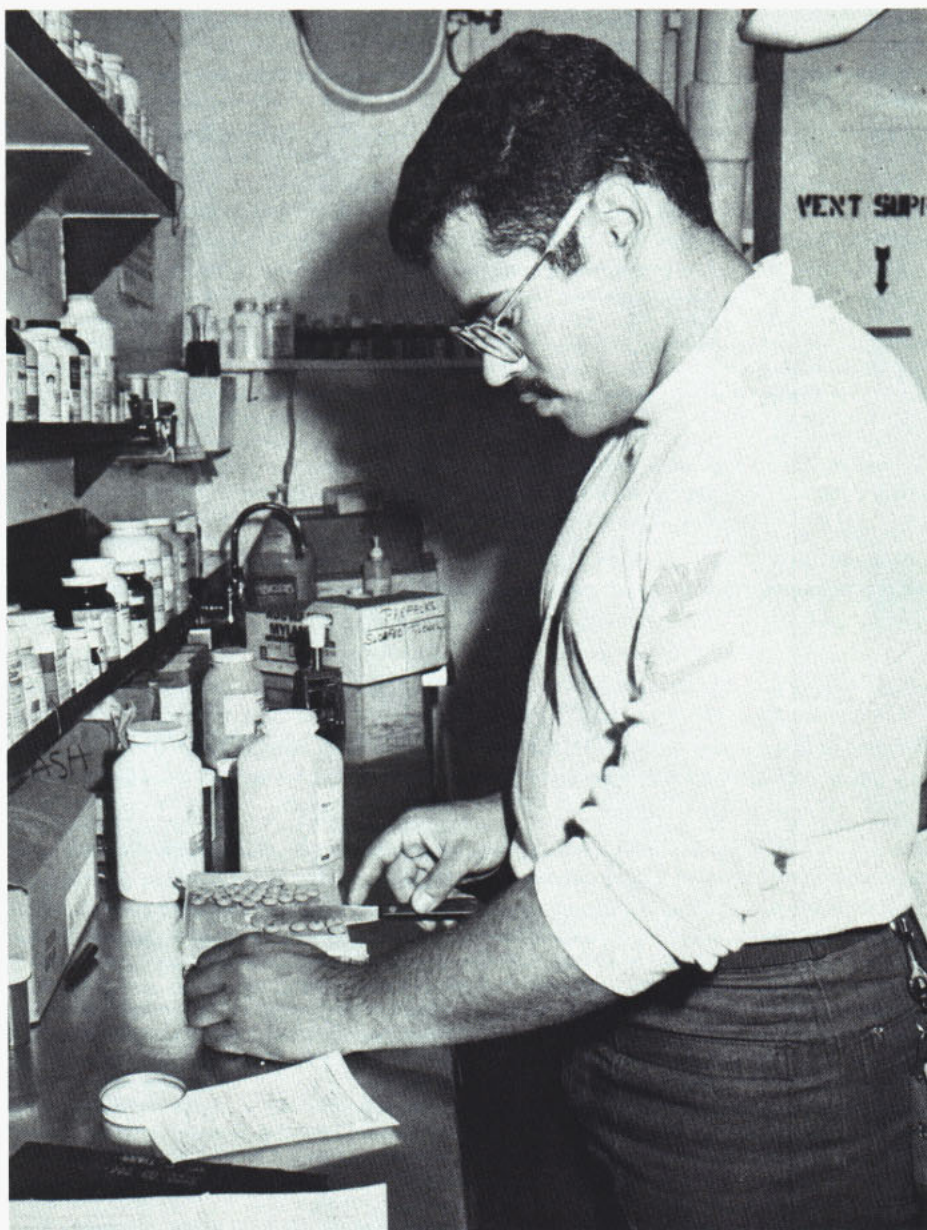
"I knew I wanted something better for myself. I guess that's why I went into medicine. Where I come from was so negative that I wanted to do something positive."

Rivera has a calm, meticulous air about him; his dungarees are neatly pressed and even his Navy-issue boots shine. Stenciled on his spotless white shirt is a red cross. To mankind it's a symbol of healing; to Rivera, it's a symbol of dedication.

The 24-year-old New Yorker whose family comes from Puerto Rico loves to talk about his work. "What I like most about the medical field is that it allows me to help people and truly make a difference in their quality of life." Rivera said, "My ultimate goal is to become a Navy flight surgeon."

Currently working in the *Saratoga's*

Hospital Corpsman 3rd Class Heriberto Rivera accounts for every pill issued from the pharmacy.



pharmacy and emergency room, Rivera explains that the corpsmen on his ship are rotated into different jobs in the department every month, enabling them all to learn various skills.

"I'm able to do things in the Navy that a nurse in the civilian world cannot. For example, I can suture. The knowledge I've gained here is invaluable. Many people don't realize the importance of the corpsman — the job is a key to maintaining battle readiness. It's a job with a lot of responsibility. I take my work very seriously."

According to Rivera, his work in the pharmacy offers a great deal of personal and professional satisfaction. "When you are working in the pharmacy, you are looked upon with trust beyond belief. You're exposed to different types of drugs and narcotics.

"From the beginning, we're taught to give the right medication, the right dosage, at the right time. My superiors trust me and I won't let them down," Rivera said.

Rivera met his wife of four years, Maria, while living in Puerto Rico. They have a 4-year-old daughter named Natealia.

"I went to Puerto Rico as a teenager because I was having difficulties at home. My parents separated and I went to live with my grandparents. While there, I met my wife. We found we had so much in common — we both had an interest in medicine. She's now a laboratory technician. My family is everything to me," he continues. "My wife is my dearest friend and my daughter is my joy.

"After we got married, we moved to Ithaca, N.Y. Living there was great. I found a job working as a hospital aide in the intensive care unit in the Tompkins County Hospital. I learned so much there — laboratory procedures, surgical procedures. I got a lot of hands-on experience," Rivera said.

"With the experience I've gotten in the

Navy and the civilian world, I'm prepared to pursue a career in medicine, if I get the chance."

While living in Ithaca, Rivera grew to enjoy nature and the sense of community within a small town. He said he got involved as a volunteer fireman and with a first-aid squad.

He enjoyed the local football games, the river raft rallies, pancake fund-raisers and quiet walks in the woods.

"Nature gives me peace and tranquility," Rivera said. "There is something magical about seeing trees and hearing birds when you wake up in the morning. Getting involved in the community gives me that sense of belonging. Community spirit means teamwork. Community is what caring is all about. I find that sense of teamwork in the Navy."

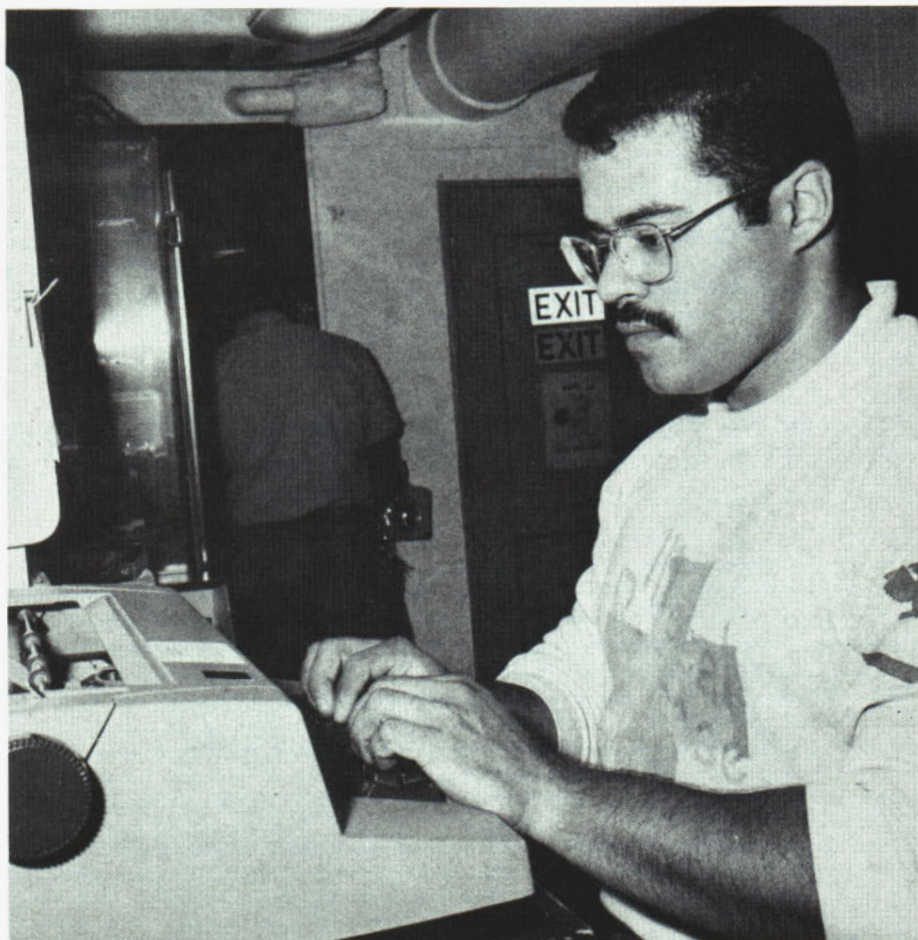
Rivera joined the Navy while living in Ithaca. For him, it was a stepping stone towards reaching his goal of obtaining a

medical degree and pursuing a naval officer's commission. "Military fever runs in my family," Rivera said.

"The Hospital Corpsman School at Naval Training Command Great Lakes, Ill., was competitive and offered comprehensive training. Compared to the other branches of the service, the Navy hospital corpsman rating is far superior. You have to have a willingness to help your fellow shipmates and a great amount of caring."

A professional in every sense of the word Rivera, said, "I want to be looked at as a person willing to help seven days a week, 24 hours a day. I want to be looked at as someone you can rely on, someone you can trust." □

Seda and Smith are attached to USS Saratoga.



Rivera gets personal and professional satisfaction from his work.

ER

On a quiet night

Story and photo by Staff Sgt. Fred Dodd

"I'm scared," squeaked the boy on the examination table.

"I'll talk you through it," the doctor assured him in a deep, soothing voice.

"It hurts!"

"I know, I've been through this myself," the doctor said compassionately.

"OK, it's done. I just have to pull it through." He pulled carefully on the thread, closing the child's small wound.

"Are you done yet?" the 11-year-old asked. His voice sounded more curious than pained.

"I just have to tie it."

"Is it over?"

"Just a second . . . your name is Thomas, right?" he asked, taking the child's mind off the discomfort.

"Yeah. Call me Tom. Is it over yet?"

"It's over," the doctor said as he tied off the stitch.

The Branch Hospital emergency room at Twenty-nine Palms, Calif., helps scores of patients during any given weekend. Navy medical personnel staff of all specialties — doctors, nurses, corpsmen and other health technicians — serve in such emergency rooms.

During this night's watch, in a little more than two hours, the following cases were seen:

7:35 p.m. — The ER receives a call about an accident at the fitness center. An ambulance with an emergency medical technician responds, and returns

seven minutes later with a patient and his two companions. The patient's face is frozen in agony.

"He was bench-pressing and the weights dropped on his chest," one of the victim's buddies explains to the doctor, Lt. Cmdr. Laurence Lo. The patient, a Marine staff sergeant from a nearby air station, is carefully transferred from the gurney to an examination table.

"Where does it hurt most?" Lo asks.

"Right in the center," is the weak reply.

As Lo tries to learn more about his patient's pain, a corpsman is taking blood pressure and temperature readings. "Physical fitness can be hazardous to your health," jokes Lt. Cmdr. John Chemycz, a staff nurse, trying to lift the injured Marine staff sergeant's spirits.

The patient is quickly hooked up to an electrocardiogram machine to check his heartbeat.

7:38 p.m. — A corporal here on a training mission is brought in by a Navy corpsman. The Marine has an eye infection caused two days earlier by a poke from a stray finger. The corpsman who accompanies him, Hospital Corpsman 2nd Class Ross Lowry, is busy flushing the eye.

7:39 p.m. — Another Marine, a Pfc., comes in, wearing a bandage on his arm. Lo removes the bandage, revealing a nasty burn running from the man's fingers to his elbow. "I knocked over a

lit Coleman lantern," the Pfc. attached to the arm explains. Lo carefully removes the dead skin from the wound, to protect it from infection.

8:11 p.m. — Doctors and corpsmen continue to work on all three patients. An X-ray technician takes a picture with a portable X-ray unit of the weightlifter's chest and leaves to develop the film.

8:15 p.m. — The technician returns and hands the X-rays to Lo, who studies them with Chemycz. Neither can spot any abnormalities, and Lo determines it's safe to move the weightlifter who is then sent for more X-rays. Lo tells the technician the exact X-ray angle he's looking for.

8:20 p.m. — Lo continues to dress the Pfc.'s burn. "It's a second-degree burn," Chemycz explains. "The burn got through some layers of skin, but not its full thickness."

8:25 p.m. — The weightlifter is still being X-rayed, and the eye infection is cleaned out. Lt. Cmdr. Thomas Hyatt, the other doctor on duty, inspects the corpsman's work.

8:29 p.m. — Hyatt takes a call from a mother wanting advice on medication for a 2-year-old. He explains the dosage she should use.

Medical personnel provide attentive care to a variety of patients admitted to the Emergency Room. Here, a burn victim has his wound cleaned.

8:30 p.m. — With his burn cleaned and freshly wrapped, the Pfc. leaves for his barracks. The X-rays are complete on the weightlifter. "You have a small fracture of the breast bone," Lo tells him. "Nothing serious, but you'll have some discomfort. If you have more pain, go to your battalion aid station right away." Since no other treatment is needed, his buddies take him home.

9:10 p.m. — Chemycz gives pain medication to a woman who comes in complaining of ear pain. After she leaves, the ER quiets down. Hyatt finishes up some paperwork.

Chemycz explains the branch hospital

has a "level-3" ER, which means there is a physician aboard at all times and a nurse is on call. Chemycz is only one of two ER-certified branch nurses at this facility, so he often works long hours. Ward nurses work the ER eight hours a day, but Chemycz or Lt. Diane Michal remain on call at all times.

The doctors see more than their share of the action as well. Hyatt had worked at his regular clinic all day before reporting for ER duty, which will last until 8 a.m. the next day. Chemycz said that, because of the personnel and equipment shortages, the hospital doesn't handle seriously wounded or seriously ill pa-

tients. They are sent to larger hospitals, such as those in Palm Springs, San Bernardino or even Camp Pendleton.

"Our main job here is to stabilize patients and get them to the care they need," Chemycz said.

9:17 p.m. — A gunnery sergeant having chest pains is rushed in from the field. He has a history of heart problems, including a heart attack, coronary artery disease and heart surgery.

9:19 p.m. — Another Marine, suffering severe abdominal pain, is brought in. Writhing in pain, he has his arms wrapped tightly across his chest.

9:20 p.m. — An electrocardiogram is run on the gunny and he is given nitroglycerin.

9:22 p.m. — The Marine with abdominal pains is sent to X-ray. Hyatt is working to get the gunny transferred to a larger facility.

9:38 p.m. — A heat casualty is brought in from the field. Treatment begins. Hyatt walks over to the gunnery sergeant. "You need to be in a hospital tonight. Then we'll see about getting you back to North Carolina. Are you feeling OK now?" he asks.

"Just a little tightness," is the reply.

9:44 p.m. — Hyatt is on the phone with the Hi-Desert Hospital making arrangements for the gunny's transfer.

9:45 p.m. — The Marine with the abdominal pain returns from X-ray. It is discovered that he is suffering from pneumonia and inflammation of his rib cartilage.

10:10 p.m. — The heat casualty has responded to treatment and he is released.

And so it goes . . . throughout the night.

From 3 p.m. to 11 p.m., 30 patients were treated in the ER. The cases varied from a baby with a light diaper rash to life-threatening emergencies. The two doctors, nurse and corpsmen said it was a typical night. □



Dodd works at the Joint Public Affairs Office, Marine Corps Air Ground Combat Center, Twenty-nine Palms, Calif.

Navy medicine maintains tradition of caring

Story by JO3 Fred Frailey

When one thinks of the Navy, images of ships and weapons manned by highly trained sailors are conjured up. That's an accurate image, as far as it goes. But we need to remember, while men and women work to maintain the weapons and equipment that often occupy center stage, Navy medicine works behind the scenes to maintain the health of today's sailors, marines and their families.

The history of the Navy Medical Corps covers the history of American medicine in general and the history of the Navy itself. Any history of Navy medicine goes back to the days when a youthful United States was just establishing itself as a naval power.

During the Navy's early days, Navy medicine was not really a formal organization; enlisted members were detailed to assist the ship's surgeon in caring for the sick and wounded. These assignments were temporary. Years later however, crew members were assigned on a more permanent basis. They were called "loblolly boys," a name derived from the gruel fed to patients. In 1814, Navy Regulations provided that the loblolly boy was to serve the ship's surgeon and was to be called the "surgeon's steward."

Not long after, Navy medicine got organized. The Bureau of Medicine and Surgery was created by Congress on

Aug. 31, 1842, with Surgeon William Paul Crillon-Barton serving as its first chief. The title of Surgeon General was not used until some years later when William M. Wood assumed the office; nor was Navy medicine actually referred to as the "Medical Corps," except in popular usage. The Appropriations Act of 1871 officially designated the Medical Corps as a distinct entity.

As the duties evolved and organization developed, so did the terminology.

In time of battle, the wounded were taken to the forward part of the ship, below the waterline, where it was safe from cannon fire. Originally referred to as the "cockpit," this area later became known as the "sick berth" and eventually the term became the present day word "sickbay."

The Hospital Corps became an organized unit by an Act of Congress on June 17, 1898. Within two years, during the Boxer Rebellion in China, the first member of the Hospital Corps was awarded the Medal of Honor. Three more Medals of Honor were awarded to Navy corpsmen prior to World War I.

During the Great War, the Hospital

Corps' image and reputation were enhanced, especially by sailors serving in the field with the Marine Corps. By the end of World War I, 15 medical person-



At triage hospitals in France during World War I, Navy medical personnel made do in tents among ruins of war-ravaged buildings.

The first Navy flight nurse to set foot on any battlefield, Ens. Jane Kennedy, bends over a wounded Marine on the airstrip at Iwo Jima. (U.S. Navy photo.)

nel had been killed in action, with 146 wounded. Two more Medals of Honor had been awarded, along with 105 other awards and commendations.

Of 15 Navy enlisted men who received the Medal of Honor during World War II, seven were hospital corpsmen, a unique distinction, since none carried weapons. Hundreds of Bronze Stars, Navy Crosses and Silver Stars were awarded to Navy Corpsmen. To summarize the hospital corpsmen of World War II, 97 of every 100 soldiers wounded in the field survived because a Navy corpsman was there.

The Marine Corps Memorial symbolizes the raising of the flag on Mt. Suribachi, Iwo Jima, in one of the last battles of World War II. Unknown to



many, Navy Pharmacist's Mate John Bradley participated in that historic moment.

Navy corpsmen were kept busy during the Korean War, not only in the thick of combat on the ground, but aboard the hospital ships *USS Consolation*, *Repose* and *Haven*. During this conflict, heli-

copters first played a significant role in medical evacuations. This proved to be such an effective means of handling the seriously wounded that first *Consolation*, then *Repose*, and *Haven* were modified with helicopter landing platforms.

Repose also saw service in Vietnam, as did another Navy hospital ship, *USS Sanctuary*. Navy hospital corpsmen distinguished themselves both in the jungles, under fire, and aboard the hospital ships, where they put in remarkably long hours; *Sanctuary* once spent a record 121 days at sea.

In subsequent military engagements, including one of the most recent, Grenada, Navy corpsmen have been on the line saving lives, often at the cost of their own. When terrorists bombed the Marine Barracks in Beirut, Lebanon, in 1983, 15 Navy corpsmen were among those killed.

Today, the hospital corpsman serves the Medical Corps doctor in a variety of demanding roles in almost every conceivable location, from modern hospitals in large metropolitan cities to the small outposts of the most isolated islands and, of course, aboard ships in the fleet around the globe.

Navy Dental Corps

Aug. 22, 1987, marked the 75th anniversary of the Navy Dental Corps. Many changes and advancements have taken place since President Taft signed a bill authorizing dental surgeons to be



Tradition of caring

a part of the Navy Medical Corps. Five years after the Dental Corps' inception, the United States entered World War I, on April 6, 1917. Reaching a wartime peak of 500 officers, two of its members were eventually decorated with the Medal of Honor.

An article in the January 1921 *U.S. Naval Medical Bulletin* advocated the use of "ancillary personnel" to extend the services of Naval dental officers and to emphasize preventative dentistry. As a result, the U.S. Naval Dental School was opened as a part of the U.S. Naval Medical School in February 1923.

Initially taken from the ranks of hospital corps, the first class of dental assistants numbered only 10. From this humble beginning a new Navy tradition was born. Only two months before the attack on Pearl Harbor, the Surgeon General's annual report recommended the procurement and retention of significant numbers of dental personnel for "the morale as well as the health of Navy personnel. . . ."

In World War II, over 7,000 dental officers served at more than 1,500 installations, often facing the same combat dangers as the corpsmen in the field.

Following the war, the Naval Dental School was established in Bethesda, Md. It is still active today, training dental officers in all facets of dentistry, for service wherever the Navy goes.

Today there are some 1,700 dental officers on active duty serving around the world.

In addition to general technicians, the enlisted dental rating trains individuals as repair technicians and prosthetic tech-

Navy corpsmen render first aid on the landing beaches. (U.S. Navy photo.)



nicians. For 64 years Navy dental technicians have served a valuable service to the Navy men and women, Marines and their families.

Navy Nurse Corps

There are many unsung heroes in the chronicles of American military history, not the least of which are women in the armed forces.

Although the Navy Nurse Corps officially celebrated its founding on May 13, 1908, Navy nurses were in a somewhat ambiguous status until after World War II. In the early days, they were neither enlisted nor commissioned.

During World War I, more than 1,400 Navy nurses served in the United States

and abroad. The women were not supposed to serve in direct combat, but those who served in the European units were subject to the same shelling and gassing that the troops they tended suffered. Many were even taken as prisoners and incarcerated in German POW camps. But because of their quasi-military status, they were not awarded any pay or benefits during their time as prisoners.

Not until 1947 did Congress pass Public Law 36, giving permanent commissioned status in the Navy's and Army's Nursing Corps.

Navy doctors, corpsmen, dentists, dental technicians and nurses have all served selflessly throughout the world at shore installations, in the combat zones

of the most dangerous battles in history and aboard hospital ships. Their dedication, courage, patience and skill have enabled America's fighting forces to survive and prevail. □

Frailey is a reservist with CinCPacFlt, Naval Reserve DET 520, Sacramento, Calif.

The Navy Nurse Corps was established by Congress in 1908, but nurses weren't given permanent rank status — officer or enlisted — until 1947. (U.S. Navy photo.)



The Log Book

"What's past is prologue." To help keep us mindful of our past, to help keep the present in perspective, and to give some insight into the future, All Hands presents a short review of articles that appeared in previous issues.

10 YEARS AGO

in the November 1977 *All Hands*

- Super Rapid-Bloom Offboard Chaff (Super RBOC), a larger and more effective ship-launched missile-decoy system, was approved for service use by the chief of naval operations. Super RBOC is a deck-mounted, mortar-type system which dispenses a cloud of metallic-coated fiber chaff to present a false target to incoming missiles. This new system consists of either two or four, six-round launchers that were designed to accommodate other types of decoy rounds being developed.

- In its first attempt at the operational propulsion plant examination, the San Diego-based guided missile cruiser USS

Fox (CG 33) received an overall finding of satisfactory — no mean achievement. The engineering department successfully completed a full-power run, achieved flexibility tests on all four boilers, pre-

sented three fully qualified underway watch sections and demonstrated the required proficiency and professional knowledge for sustained propulsion plant operations. □



20 YEARS AGO

in the November 1967 *All Hands*

- USNS *Redstone* (T-AGM 20) passed a major test milestone when it communicated via an orbiting satellite with shore stations at Andover, Maine, and Grand Canary and Ascension Islands. *Redstone* was one of the ships built to track and communicate with American

astronauts during manned missions to the moon and the first to be equipped with a satellite communication system which allowed it to communicate around the world via satellites.

- Four Seabees of MCB 74 noticed how much the Vietnamese children seemed to like popsicles. They wondered what would be the reaction to a giant one. Using a five-foot-long two-by-four for the stick, the four Seabees manufac-

tured a 100-pound cherry flavored popsicle. When the popsicle was frozen it was loaded onto a truck and taken out to the hamlet of Trung Nghia. The popsicle lasted a mere 20 minutes when the kids got to it — even the stick was carried off. Members of the popsicle construction team were UT2 Donnie Douglas, UT3 Charles Matthis and UTCNs Jerald Hirschman and Stephen Smith. □

40 YEARS AGO —

in the November 1947 *All Hands*

- Three U.S. submarines visited Valparaiso, Chile, in observance of Chilean Independence Day. On a South Atlantic training cruise, USS *Cutlass* (SS 478), USS *Diablo* (SS 479) and USS *Conger* (SS 477) rounded Cape Horn and arrived in Valparaiso for a three-day

visit. This was the second time that U.S. submarines had successfully navigated these treacherous waters, noted for sudden severe storms and numerous hidden reefs. USS *Sea Robin* was the first submarine to accomplish this difficult navigational feat in June of that year.

- One hundred thousand feet is a long way up, but the Navy unveiled plans to reach that altitude by means of unmanned balloons which would carry in-

struments to record unexplored atmospheric phenomena. Light in weight and unusually strong, the balloons were plastic and were expected to carry 70 pounds of scientific instruments. Balloons in clusters of three and four would be sent up to carry increased amounts of research equipment. Helium gas was to be used. Flights were planned near Minneapolis and possibly at the Naval Air Station, Lakehurst, N.J. □

Corvette or light frigate (FFL)

PETYA I/II Class

Today's Soviet navy presents a growing challenge to the United States and its allies. All Hands is presenting a series of articles describing the ships of the Soviet fleet, to provide the U.S. Navy community with a better understanding of Soviet naval developments and fleet battle capabilities.

The *Petya*-class of light frigates is designed primarily for coastal defense, although they operate regularly in the Mediterranean and frequently in more distant areas.

Displacement:

1,150 tons full load;

Length:

82 meters (269 feet);

Propulsion:

Combination diesel/gas turbines, 29 knots;

Main armament:

Two twin 76mm DP gun mounts and two ASW rocket launchers;

PETYA I has four ASW rocket

launchers and only one 5-tube torpedo mount.

The older *Petya I* units became operational in 1960. The improved *Petya II* units have two sets of five 16-inch torpedo tubes and two anti-submarine rocket launchers. Some *Petya Is* and *Petya IIs* have been modified to carry variable-depth sonar. About 65 *Petyas* have been built, and half have been transferred to foreign countries. □

PETYA I FFL



PETYA II FFL



MOD PETYA I FFL



Bearings

Navy Relief to manage *Stark* scholarship fund

In a recent ceremony held aboard USS *Stark* (FFG 31), a check for \$132,487.21 was presented to the Navy Relief Society. The check represented funds raised across the nation for the USS *Stark* Memorial Scholarship Fund.

The check was presented by Capt. Thomas O. Gabriel, CO of Destroyer Squadron Eight, to retired Rear Adm. Ralph Carnahan, national vice-president of the Navy Relief Society. The funds were the current total raised by business groups, private contributions and Navy commands, which were then deposited in a local bank for safekeeping.

Including national donations received by Navy Relief in Washington, D.C., the fund now totals more than \$400,000, according to Lt. Steve Maynard of DESRON Eight. The National Navy Relief Society, headquartered in Washington, D.C., has been designated as the administrator of the fund.

Guidelines for distribution of the funds, written by DESRON Eight staff



members, dictate that funds will provide financial assistance for post-high school educational opportunities to spouses, children and stepchildren of the 37 *Stark* sailors who died when their ship was hit by two Iraqi missiles in May.

All contributions to the scholarship fund should be forwarded to the Navy

The USS *Stark* Memorial Scholarship Fund is turned over to the Navy Relief Society. (U.S. Navy photo.)

Relief Society. Checks made payable to the Navy Relief Society USS *Stark* Memorial Fund can be sent to: Navy Relief Society, 801 N. Randolph St., Room 1220, Arlington, Va., 22203. ■

Engineering Center marks 70th anniversary

Dusk settles on a Navy aircraft carrier in the Mediterranean Sea. A "Top Gun" waits in his F-14 *Tomcat*. Its engines and afterburners thunder and a powerful steam catapult hurls the 33-ton fighter into the air with an ear-shattering roar of steam and jet exhaust — from standstill to 160 mph in two seconds.

The jet blast deflector is immediately lowered and another jet taxis onto the catapult. The launch cycle can be repeated every 30 seconds using the carrier's four catapults.

Later, with mission complete, the plane returns in pitch black to the carrier. Deck edge lights cast a red glow which barely enables the pilot to see the moving flight deck hundreds of feet below and nearly one mile ahead.

As he gets closer, the pilot can see the optical landing system and other visual landing aids. He drops to the flight deck at a rate of 600 feet per minute. Although capable of flying ten times faster, the F-14 slows to 150 mph, landing gear and flaps down. The jet's tailhook catches one of four wire arresting cables stretched across the deck. Below deck, arresting gear engines absorb the shock. The F-14 comes to a halt within a short 340 feet.

The equipment and systems that make such air operations possible were designed and developed by the Naval Air Engineering Center at Lakehurst, N.J. The center is currently celebrating its 70th anniversary. Born of necessity in World War I, NAEC has been at the forefront

of naval aviation ever since.

"If it weren't for NAEC, the Navy would find itself in the position of conducting sea-based air operations on a trial-and-error basis, or never trying anything new," said Vice Adm. E. R. Seymour, USN, (Ret.), a former commander of Naval Air Systems Command. "NAEC provides us with the opportunity to test new ideas."

The largest naval aviation facility east of the Mississippi, NAEC is home for 17 Navy, Marine, Army and DoD organizations. It is the senior and host command at the sprawling 7,400-acre base at Lakehurst, N.J. ■

— Story by Nick Grand, Public Affairs Officer, Naval Air Engineering Center, Lakehurst, N.J.

Valley Forge wins Ney award

USS *Valley Forge* (CG 50), a San Diego-based guided missile cruiser, has been named winner of the 1987 Ney Memorial Award for medium-size ships. The Ney Award recognizes excellence in food service operations in Navy commands ashore and afloat.

This was *Valley Forge's* first opportunity to compete in the Ney competition since being commissioned in January 1986.

"The key figure is Mess Management Specialist Senior Chief Dante B. Bagay-

bagayan," said Lt. Cmdr. Charles T. Vickers, the ship's supply officer.

But Bagaybagayan was quick to give the credit to the crew. "I think I had the best crew in the fleet. I can't pinpoint any one person. Everybody worked hard," he said.

The team of mess management specialists and mess cooks worked many long, hard hours throughout the year according to Bagaybagayan. They set a standard of excellence in food preparation, service and cleanliness that provided

the crew of *Valley Forge* with outstanding meals on a daily basis.

He also mentioned the support provided by other departments on the ship, from the engineering department's support of refrigeration facilities to the efforts of crewmembers from every division aboard ship temporarily assigned to work in the mess department.

"Consistency is the key," Vickers said. "If the Ney Award inspectors were to come back aboard *Valley Forge* today, we would still show ourselves well." ■

Awards to new aviators

The chief of Naval Air Training has announced the winners of three naval aviation training awards.

Ens. Jon P. Whitten, assigned to VF 101, Oceana, Va., will receive the Capt. David McCampbell award for Navy students. He earned his wings at VT 25, NAS Chase Field, Texas.

1st Lt. Charles O. Hobaugh, with VMA 331, MCAS Cherry Pt., N.C., will

be awarded the Maj. Joseph Foss award for Marine Corps students. Hobaugh received his wings at VT 7, Meridian, Miss. Both awards are sponsored by the American Fighter Aces Association for naval aviation students with outstanding performance in air combat maneuvering and who possess exemplary qualities of leadership, integrity and devotion to duty, with a strong inclination toward a career

in Navy/Marine aviation.

Ens. John W. Hilterman, HSL 45, North Island, Calif., has been tagged for the Orville Wright Achievement Award. Sponsored by the Daedalian Foundation, this award goes to the student who achieves the highest overall grades for a six-month period. Hilterman earned his wings at HT 18, NAS Whiting Field, Fla. ■

Coral Sea joggers get green flag

The workday is over. A sailor on board the Norfolk-based USS *Coral Sea* (CV 43) changes into gym shorts and T-shirt for a run in the hangar bay. But there's a question: is it safe?

The answer is easy to discover, thanks to the recent efforts of Parachute Rigger Chief Ron Spinner and Aviation Boatswain's Mate (Handler) 1st Class Mike Arroyo. Two flags hang just outside Hangar Deck Control to signal runners whether it is safe or not.

A green flag with a smiling jogger indicates safe running conditions. A red flag with a frowning jogger and a "forbidden" mark secures the hangar.

"The problem before the flags was that people would be told by their super-

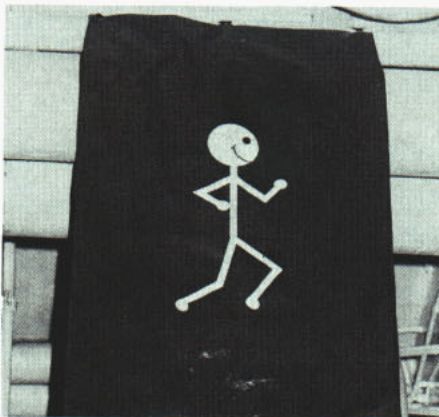


Photo by PH3 Mike Steens

visors it was safe to run, and when they started running the ship's safety personnel would tell them it wasn't safe," said Arroyo. "In order to alleviate confusion,

Chief Spinner came up with the idea of the flags."

Safety department personnel are pleased with the flag system, because it makes their jobs easier. And runners are happy too.

"The flags have really helped solve the problem, not only for those of us who work in the hangar bay, but also for the runners themselves," said Arroyo. "Instead of having to track down someone to get permission to run, all they have to do is look for the flags."

Credit for the design and construction of the flags goes to PR3 Michael Williams and PR3 Steve Riedel. ■

— Story by ACAN William J. Doran,
USS *Coral Sea*

Mail Buoy

Statue out of uniform

The other day my wife and I were walking across the Bethesda Naval Hospital compound and a young sailor approached us. My wife, HMC RuthAnn Coppola, corrected the sailor on his appearance. His peacoat was open and his hands were in his pockets. We've always held the belief that coats should be buttoned and hands stay out of the pockets. That's why gloves were invented. OK, so we both agree. You're probably wondering, "What's Coppola's beef this time?"

Here's the beef. Who was the approving authority on the statue that's going to grace the Navy Memorial being built here in D.C.? The blue jacket represented by the statue also has his hands in his pockets and the coat is open to the elements. Great. Everybody from Maine to Oregon is going to see this guy standing there, OUT OF UNIFORM! Tell me it ain't so, Shane.

—HMC(SS) Joseph A. Coppola
Bethesda Naval Hospital

• You can corner the approving authority for the statue design by contacting the United States Navy Memorial Foundation, Box 12728, Arlington, Va. 22209-8728. — Ed.

NavSta is AirSta

I would like to comment on the article titled *Alaska* published on page 28 of the Jan. 87 issue. The caption for the picture on page 31 refers to NavSta Adak. In May of 1984 NavSta Adak officially became Naval Air Station, Adak.

—Lt. Kenneth O'Brien
FPO Seattle, Wash.

A moving question

We have a question regarding the firepower of the USS *New Jersey*, specifically the nine 16-inch guns being fired at the same time, sometimes referred to as a "full broadside."

If the ship was sitting dead in the water at the time of a full broadside, how much sideways movement would there be? Less than one foot or greater than one foot?

We hope that you can answer this question in your usual timely and efficient manner.

—STS2 (SS) Marcus Crawley
—BMC Raymond Harrell
—MA1 P. Michael Hanners
Columbus, Ga.

• We contacted the folks at the Combat Systems Engineering Command here in Washington. According to their battleship ex-

perts, the sideways movement of the ship, sitting dead in the water after a full broadside, would be measured in "mere inches at most." Because of the ship's enormous displacement (59,000 tons full load), the recoil from the guns would move the ship less than a foot. — Ed.

Misleading term

In regard to the photograph and caption inside the front cover of your June 1987 edition, the term "Seabee beachmaster" is somewhat misleading. The individual pictured is CMCN Rick Fransden, a member of Beach Party Team Bravo of Beachmaster Unit One. Within each Beach Party Team, there are at least four Seabees who serve as LARC mechanics and Heavy Equipment Operators. However, CMCN Fransden, as well as all other members of the Beach Party Teams, has completed extensive cross-training in the various positions on the team. He thus joins a unique group of Boatswain's Mates, Gunner's Mates, Signalmen, Radiomen, Hospital Corpsmen, Constructionmen and Equipment Operators who have gone beyond their ratings and have earned the stand-alone title "Beachmaster."

—M. E. Moffat
Commanding Officer, Beach Unit One
San Diego

When is a Skorry not a Skorry?

Your article on page 40 of the July *All Hands* describes the *Kotlin* Class DDG. While the write up and silhouette are indeed of a *Kotlin*, the photograph is in fact of a *Skorry* Class DD. We in the Army are always glad to provide assistance to our maritime comrades-in-arms.

—Roy J. Allen
LTC, USA, Virginia Beach, VA.

• This error was due to an incorrectly labeled photograph, provided by a primary source. *Skorry* was correctly profiled in the September 87 *All Hands*, pg. 46. Several Navy people previously brought the problem to our attention; glad the Army finally got on board. — Ed.

Pigs and roosters again

In browsing through an old November 1986 issue of *All Hands*, a question on page 41 was asked by HMC (SS) Joseph A. Coppola, concerning the significance of the pig and rooster tattoos and their placement.

The belief among old sailors is that the rooster has the capability of flying and will

thus save itself from drowning. As for the pig, it will sever its own neck with its hooves if it tries to swim, causing it to bleed to death.

As for tattoo placement, I believe the pig is on the port ankle and the rooster on the starboard. I hope this eliminates any shadow of a doubt in regard to this situation.

—Kent P. Keelan
Homestead, Fla.

• Why would sailors seeking to avoid drowning carry as a talisman the image of an animal that can't swim without killing itself? — Ed.

Wrong Hornet

I was reading the November 1986 issue of *All Hands* on the sinking of the USS *Wasp* by the Japanese submarine I-19 on Sept. 5, 1942. I want to set the record straight that the carrier *Hornet* was CV 8 and not CV 12. I was on *Hornet* CV 8 in that action. The ship was also hit and badly damaged on Oct. 26, 1942 in the battle of Santa Cruz. *Hornet* (CV 12) was commissioned at a later date.

—Walter E. Bragg
Landsdale, Penn.

Reunions

• USS *Terry* (DD 513) — Reunion proposed. Contact Frank L. Wey, 1519 Wookley Ave., Terre Haute, Ind. 47804-2628; telephone (812) 232-7330.

• AS 305 — Reunion planned. Contact Dick Carter, Rt. 14 Box 385, Tyler, Texas 75707; telephone (214) 566-1662.

• USS *San Jacinto* (CVL 30) — Reunion January 1988, Houston. Contact J.C. Lohr, 738 Campbell Dr., Belpre, Ohio 45714; telephone (614) 423-7373.

• 116th Aslt. Hel. Co. — Reunion April 15-17, 1988, St. Louis, Mo. Contact Arthur Silacci, 485 W. Sierra, Clovis, Calif. 93612; telephone (209) 299-7789.

• USS *Warton* (AP 7) — Reunion April 17-20, 1988, San Antonio, Texas. Contact George Howlett 110 Central Ave., Malden, Ma. 02148; telephone (617) 324-6121.

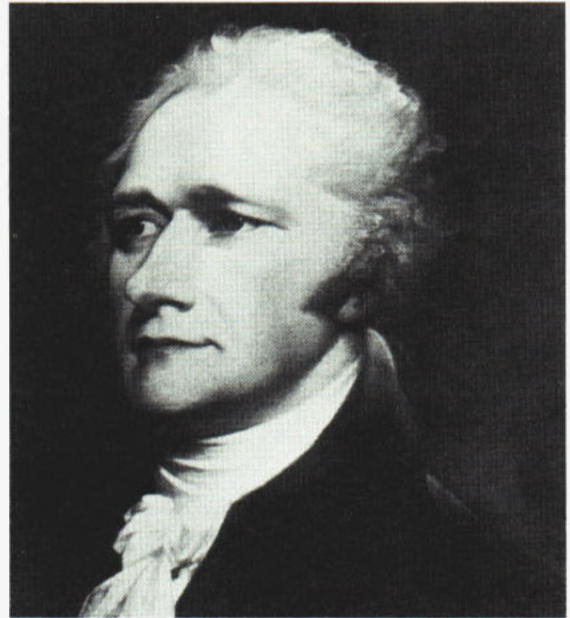
• USS *Cowell* (DD 547) — Reunion May 1988, Las Vegas. Contact Jacob Jacobs, 1633 S. 48th St., Lincoln, Neb. 68506; telephone (402) 489-7350.

• USS *Arkansas* (BB 33) — Reunion May 26-29, 1988, Little Rock, Ark. Contact Joseph Walker, 4203 Hollow Hill Dr., Tampa, Fla. 33624; telephone (813) 962-3024.

U.S. Constitution—signers and ships named for them

Alexander Hamilton — 1757-1804

Soldier, lawyer and political theorist, Hamilton was a leading advocate of centralized government. The only delegate representing the state of New York at the Constitutional Convention, Hamilton, an aristocrat by nature, distrusted unchecked democracy and disliked the idea of forming a republic. Even after the delegates agreed on compromises limiting democracy, Hamilton and others maintained a hard line on the issue and initially refused to vote for adoption of the document. Only after Benjamin Franklin introduced a resolution, calling for the members to sign the Constitution as delegates of the states they represented and not as individuals, did Hamilton put his personal feelings aside and affix his signature to the document. Later, Hamilton joined with James Madison and John Jay in writing a series of newspaper essays explaining the value and virtues of the Constitution. These essays, known as the *Federalist Papers*, helped win ratification of the Constitution in Hamilton's home state of New York.



USS *Alexander Hamilton* (SSBN 617)

Class: Lafayette

Displacement: 7,300 tons surfaced, 8,250 submerged.

Dimensions: length/beam/draft: 425 x 33 x 31.5 feet.

Torpedo tubes: 4 (bow)

Missiles: 16 tubes for *Poseidon C3* submarine-launched ballistic missile.

Propulsion: steam turbine powered by water-cooled nuclear reactor.

Speed: greater than 20 knots.

Complement: 139 (13 officers and 126 enlisted men).



‘House calls’ in the Pacific